Disabled Services Division
Wheelchair Repair
Pre-Screening Questionnaire

Date of initial Contact: __________ DS Staff Initials: ______________

Mr.
Ms. LAST NAME: _______________________ FIRST NAME: _________________________________ MI: _______

ADDRESS: ____

CITY: _________________________________ STATE: ______________________________ ZIP: _____________

HOME PHONE: __________________________Alternate Phone/Cell: ____________________________

Are you a Duval County citizen__________ if no stop, Inform customer assistance is for Duval County residents.

Is this your only work wheelchair? ______ yes _____ No
If no, is the second wheelchair manual? _____Yes _____ No

Explain if No: ____

____

____

Do you have Medical insurance? _____________________________

Have you been told by the Insurance Company these items are not covered? If yes, why

____

____

____

____

Do you have an alternative means to pay for these repairs? _________________

Disabled Services Division
Wheelchair Repair
Pre-Screening information

Income information:

Number of persons in your household ______________________________

What is your current household income:(monthly) ______________________

Wheelchair Information:

Repairs are limited to $500.00, if qualified, only one repair will be approved for the life of the wheelchair.

What type of mobility device needs to be repaired? Electric w/c, etc.?

____

Typical types of repairs normally offered: Batteries; cords; brakes; arm rests covers, etc.

Brand /Manufacturer name: ________________________

Model number: __________________________________

Serial Number: __________________________________

Age of equipment: _______________________________

What needs to be repaired?

____

____

We will notify you by mail (if you qualify). We cannot guarantee that repairs will be made, but we will do the best we can. All repairs are subject to funding availability .

DISABLED SERVICES DIVISION
117 W. Duval Street, Suite 205 | Jacksonville, FL 32202 | Phone: 904.630.4940 | Fax: 904.630.3476 | TTY: 904.630.4933 | www.jaxada.com

Disabled Services Division
Wheelchair Repair
Qualification

Proof of Income: ________________

Identification: _________________

Vendor Assigned: _____________________________________

Wheelchair Repair Quote amount: _______________________

TECHNICIANS ANALYSIS: ____

____

____

____

PARTS TO BE ORDERED: YES_______ NO_________

REQUIRED ACTION/FOLLOW-UP: ____

____

____

____

ESTIMATED COMPLETION DATE: ____________________________________

RESOLUTION: ____

____

____

Disabled Services Division
Wheelchair Repair
Qualification

Approved: yes _______ No________

Reason for not Approving: ____

____

____

________________________________ ________________________________
Disabled Services Staff Signature Date

________________________________ ________________________________
Disabled Services Manager or Designee Signature Date

Revised 3/2/15KM