WRAP
Wheelchair Ramp Accessibility Program

Application for Service

Date of Application	Referred By / How did you hear about WRAP?

SECTION 1 APPLICANT INFORMATION

Name	Hospital of Choice:	
Address		
City	State	Zip
Phone 1	Phone 2	
Email Address	Birth date	
Diagnosis	Do you use: ☐ wheelchair ☐ walker ☐ other ☐ none	
Are you a US Military Veteran? ☐ Yes ☐ No	If Yes, Branch of Service?	
Do you live alone? ☐ Yes ☐ No	Do you own your home? ☐ Yes ☐ No	
Current/previous employer:	Phone #:	

SECTION 2 CONTACT INFORMATION (If other than applicant)

Name		
Address		
City	State	Zip
Phone 1	Phone 2	
Relation to applicant	Contact instead of applicant? ☐ Yes ☐ No	

SECTION 3 SERVICE REQUEST Please check the service(s) you are interested in receiving:

Services that do not require financial qualification	
☐	Contractor information for ramp construction and/or other home modifications
☐	Referral to a vendor for purchase &/or installation of a modular or temporary ramp
☐	Referral to an agency that can help fund home modification projects such as a ramp
Services that require financial qualification	
☐	Home visit to help determine access options and discuss ways WRAP can assist
☐	Temporary ramp on loan installed by WRAP volunteers. (availability is limited)
☐	Permanent ramp design and construction -Materials purchased by applicant
☐	Permanent ramp design and materials - WRAP leadership for construction by your family & friends
☐	Permanent ramp design, materials and construction - Applicant has no funds or labor to contribute
☐	Exterior steps design modification and construction
☐	Handrails
☐	Repairs

Ramp needs to be installed within (check one)	☐ 30 days	☐ 1-3 months	☐ 3-6 months	☐ 6 months+

Ramp will remain in use for (check one) ☐ 1-6 months ☐ 6-12 months ☐ 1-2 years ☐ Permanently

This Section for Use by WRAP Staff

SECTION 4 HOUSEHOLD FINANCIAL INFORMATION

Please complete this section regardless if you are requesting financial assistance

a. Estimated Monthly Household Income

Resident 1	**Amount**	**Resident 2**	**Amount**
Wages / Earnings		Wages / Earnings	
Supplemental Social Security Ins. (SSI)		Supplemental Social Security Ins. (SSI)	
Social Security Disability Insurance (SSDI)		Social Security Disability Insurance (SSDI)	
Other Income		Other Income	
Other Income		Other Income	
Total Monthly Income 1		Total Monthly Income 2	
Resident 3	**Amount**	**Resident 4**	**Amount**
Wages / Earnings		Wages / Earnings	
Supplemental Social Security Ins. (SSI)		Supplemental Social Security Ins. (SSI)	
Social Security Disability Insurance (SSDI)		Social Security Disability Insurance (SSDI)	
Other Income		Other Income	
Other Income		Other Income	
Total Monthly Income 3		Total Monthly Income 4	
		Total Monthly Household Income	
		x 12 months = Total Annual Household Income	

b. Liquid Assets	**Amount**
Savings Account Balance	
Cash Value of Stocks, Bonds, CDs	
Total Liquid Assets	

c. Estimated Monthly Household Expense	**Amount**
Rent or House Payment	
Utilities (gas, water, electric, home or cell phone, Internet, etc.)	
Property Taxes	
Auto Loans and Insurance	
Health/Life Insurance	
Medical Expenses and Prescriptions	
Credit Card Debt	
Groceries	
Other Expenses	
Total Monthly Household Expenses	
x 12 months = Total Annual Household Expenses	

SECTION 5 TITLE 19 &/OR WAIVER INFORMATION

Are you on Title 19?	☐	Yes	☐	No	State ID #
Are you on a Waiver program?	☐	Yes	☐	No	Type of Waiver
Name of Caseworker					
Agency of Caseworker					
Agency Address					
City			State		Zip
Agency Phone			Fax		
Caseworker Email Address					

SECTION 6 APPLICANT CONSENT Please read and initial each item. Then, sign and date below.	
	I hereby agree that the information I have provided is accurate to the best of my knowledge. I understand that any change in my financial status will be subject to reassessment.
	I give the WRAP Coalition permission to verify any information contained in this application and that I may be asked to provide a Dr.'s note/prescription, a copy of a current bank statement, a pay stub or other proof of income, a copy of my most recent tax return and/or proof of identification.
	I hereby authorize WRAP to release and exchange relevant information from this application to other agencies and/or organizations which might be a resource to secure funding and/or assist me with my home access needs.
	I understand this assistance is provided for homeowners who intend to remain in the home for the foreseeable future.
	I agree that by completing this application, I am freely requesting assistance from WRAP, and I absolve the WRAP Coalition and it's volunteers from any liability what so ever.
	In the event WRAP is able to fund and/or construct a ramp for me, I absolve WRAP and/or it's volunteers from any liability for any injury or death that might occur due to any accidents from improper function, malpractice, or for any other reason while said ramp is in my keeping. I agree to maintain and repair said ramp thereby, not holding any WRAP Coalition member responsible for any injury, harm or damage to myself, others or property during use of ramp while it is in my keeping.
	In the event WRAP and/or it's volunteers is able to fund and/or construct a ramp for me, I agree that when the ramp is no longer needed, I or my family will make an effort to contact WRAP in order to donate the ramp/materials. A WRAP volunteer will then collect the ramp/materials and store them for use by others in the community.
	I authorize the WRAP Coalition to use photographs and information about me for promotional and news release purposes in any print publication or electronic media. I realize that I will receive no payment in connection with any publication or use of these photographs and I waive claims to any such payment. This authorization will not expire.
	I authorize the WRAP Coalition to contact my former/current employer to inquire about a donation to fund partial or all of the expense of my ramp if I am unable to provide funds to the WRAP Coalition for the materials needed for my ramp. I realize that my former/current employer has no obligation in providing a donation. This authorization will not expire.
	As a client of the WRAP Coalition, I recognize the following: I will be considerate of the WRAP volunteers and their property. I or anyone in my home will refrain from smoking inside or outside my home while the WRAP volunteers are present. I will provide a safe environment for the staff including: securing family pets and having no visible weapons in my home while the WRAP volunteers are present.

Applicant Signature: **Date:**

Return Application to:

Wheelchair Ramp Accessibility Program
(WRAP)
PO BOX 276
ELY IA 52227

Or email your application to
intake@wrapiowa.org