New Jersey Office of the Attorney General
Division of Consumer Affairs
Office of Consumer Protection
Wheelchair Lemon Law Unit
P.O. Box 45026
Newark, New Jersey 07101
Phone: 973-504-6226
E-mail: lemonlaw@dca.njoag.gov
Website: www.njconsumeraffairs.gov/

Instructions for Completing the Application for Wheelchair Lemon Law Dispute Resolution

Please complete the attached application by printing clearly in dark ink. Be accurate and thorough. You must attach copies of all relevant documents, including the sales contract or lease agreement, service or work orders, and correspondence between you and the manufacturer, or its authorized dealer. Do not send your original documents.

Please be advised that any information you supply on the attached application may be subject to public disclosure. If an investigation into the matter is conducted, the information is subject to public disclosure only after the completion of the investigation. You are also advised that the completed complaint form is a "government record," which the Wheelchair Lemon Law Unit may be obligated to provide to anyone making a request pursuant to the Open Public Records Act (OPRA).

You are further advised that pursuant to Section 4B of Executive Order No. 26, information concerning any individual's medical, psychiatric or psychological history, diagnosis, treatment or evaluation is not a government record subject to public access.

Sign and return the completed application, together with copies of all relevant documents, to the New Jersey Division of Consumer Affairs, Wheelchair Lemon Law Unit, P.O. Box 45026, Newark, N.J. 07101.

The Wheelchair Lemon Law Unit will review your application for completeness and eligibility. If the application is approved, you will be notified and asked to forward a filing fee of $50. Do not send the filing fee until you are notified to do so. If your application is rejected, it will be returned to you with a statement of the reason(s) for its rejection.

Please remember to sign and date the application. Failure to complete any question or submit all required documents may result in the rejection of your application.

Notice

Under this program the decision of the Director of the Division of Consumer Affairs is binding on both parties, subject to an appeal to Superior Court by either party. You may wish to consult with an attorney before participating in this program, since the manufacturer will be represented by an attorney.

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Wheelchair Lemon Law Dispute Resolution

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1. Consumer Information

_____
Last name First name Middle initial

_____
Street address City State ZIP Code County

_____ _____
Home telephone (include area code) Work telephone (include area code)

_____ _____
FAX number (include area code) E-mail address

2. Attorney information (If an attorney will represent you, please provide the following information.)

_____
Last name First name Middle initial

_____
Law firm

_____
Street address City State ZIP Code County

_____ _____
Telephone number (include area code) FAX number (include area code)

3. Wheelchair information

A. Was the motorized wheelchair or power scooter purchased or leased in New Jersey? ☐ Yes ☐ No

If "No," where was the motorized wheelchair or power scooter purchased or leased? _____

B. Was the motorized wheelchair or power scooter purchased or leased? ☐ Purchased ☐ Leased

C. Manufacturer: _____ D. Model: _____

E. Year: _____ F. Color: _____

G. Special features: _____

_____

H. Serial number: _____ I. Delivery date: _____
Original date of delivery of the motorized wheelchair or power scooter

4. What is the name of the dealer from which your motorized wheelchair or power scooter was purchased or leased?

_____
Name

_____
Street address City State ZIP Code County

_____
Telephone number (include area code)

5. What is the name of the company to which you make your monthly payments?

_____
Name

_____
Street address City State ZIP Code County

_____
Telephone number (include area code)

If purchased, please give the account number: _____ .

6. Was your motorized wheelchair or power scooter purchased with a medical prescription? ☐ Yes ☐ No

7. Was your motorized wheelchair or power scooter purchased or leased through Medicare/Medicaid or other medical insurance? ☐ Yes ☐ No

If "Yes," please list the name and address of the party making payments on your behalf.

_____
Name

_____
Street address City State ZIP Code County

_____
Telephone number (include area code)

8. **FINANCIAL INFORMATION** (Review your sales or lease agreement for the exact amounts.)

Total Sales Price: including any fees, taxes and finance charges _____

Other Costs: rental fees [1] and the cost of modifications [2] + _____

A. Total Costs Incurred = _____

Cash amount paid at the time of purchase including: security deposit and trade-in allowance _____

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[1] Please attach photocopies of any rental charges you are claiming. You must show proof that you paid for the costs you are claiming.

[2] The cost of any options or other modifications arranged, installed or made by the manufacturer or its dealer within 30 days after the date of original delivery.

Total amount of monthly payments made to date (monthly payment) x (number of months) + _____

Less any rebates - _____

B. Total Amount Paid = _____

9. **Repair Information**

A. Briefly describe the defect(s) which substantially impairs the use, value or safety of your motorized wheelchair or power scooter.

_____

_____

_____

_____

_____

B. How does the defect(s) substantially impair the use, value or safety of your motorized wheelchair or power scooter?

_____

_____

_____

_____

_____

C. Is this defect the result of your abuse, neglect or unauthorized modification or alteration? ☐ Yes ☐ No

D. Have you notified the manufacturer or authorized dealer of the defect(s) by mail or e-mail? ☐ Yes ☐ No

E. Was the motorized wheelchair or power scooter ever repaired by anyone other then the manufacturer or an authorized dealer? ☐ Yes ☐ No If "Yes," where? _____

Was the repair authorized by the manufacturer or its dealer? ☐ Yes ☐ No

F. What was the date you first presented your motorized wheelchair or power scooter to the dealer/manufacturer for repair of the defect? _____

G. If your motorized wheelchair or power scooter experienced one or more defects, was it out of service due to repairs for a total of 20 or more days? ☐ Yes ☐ No

H. List the repair attempts chronologically:

Defect	Date turned in	Date returned	Days out of service

10. **Additional Information**

A. Have you previously participated in any arbitration for the defect for which you are now seeking relief?

☐ Yes ☐ No If "Yes," what was the date of the final arbitration decision? _____

B. Did you accept the decision? ☐ Yes ☐ No If "Yes," please explain and give the current status.

_____

_____

_____

_____

I certify that the manufacturer/dealer has not yet given me a refund or replacement, and that all statements made in connection with this request for dispute resolution are true to the best of my knowledge.

I am aware that I can participate in the dispute resolution program regarding this motorized wheelchair or power scooter only once, and that further applications will not be accepted after a final decision is issued in this case. I also certify that a decision has not been rendered in Superior Court regarding this claim.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment. I authorize the New Jersey Division of Consumer Affairs to send this complaint form to the company or to interested parties and to use the information in any way that is necessary.

_____ _____

Signature Date

Please indicate any special arrangements which may be necessary for a court hearing such as parking, building access, etc.

_____

_____

_____

If you have not already done so, please attach legible copies (**do not send the originals**) of the following:

- Repair opportunity letters to the manufacturer or authorized dealer
- Certified mail return receipts
- Work orders/repair invoices
- All relevant evidence of repair attempts
- Sales invoice
- Purchase order
- Finance agreement
- Lease agreement
- Rental fees
- Medicare, Medicaid or medical insurance information
- Copy of the prescription if you purchased the motorized wheelchair or power scooter through Medicare, Medicaid or medical insurance.

For Office Use Only

WLL case number _____

Assigned to _____

Date accepted _____

OAL docket number _____

Date completed _____

Approved by _____