Revised on 1.2020

The Limb Preservation Foundation
925 S Niagara Street, Suite 610
Denver, CO 80224
303-429-0688

Patient Assistance Fund Application

The mission of The Limb Preservation Foundation is to support the prevention and treatment of limb-threatening conditions due to tumor, trauma or infection. The Foundation strives to assist extremity patients to improve their health and wellness, and overall enjoyment of life.

All applications must be coordinated by a social worker or healthcare professional who will attach a qualifying letter of assessment. Applications requesting funding that exceed the maximum limitations will not be reviewed.

Client Biographical Information

This section is to be completed by the patient.

All fields are required. Please provide explanation for incomplete items.

Date of Application: _____ Date of Birth:_____

Patient Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Cell Phone: _____ Home Phone: _____

Email Address:_____

Age:_____ Gender: ☐ Male ☐ Female

Race:

American Indian/Native Alaskan ☐ Caucasian ☐

African American ☐ Hispanic ☐

Asian /Pacific Islander ☐ Other

Are you a veteran of the US Armed Forces: No

Patient Insurance Coverage

This section is to be completed by the patient and/or coordinating social worker or healthcare professional.

Does Patient have Private Health Insurance? No

Name of Provider: _____

Annual Deductible Amount $ Terms

Does Patient have Medicare? No

If you receive Medicare do you have a secondary insurance? No

Does Patient have Medicaid? No

Patient Financial Information

Patient Employer: _____

Gross Annual Salary $_____ Take Home Monthly Income $_____

Spouse/Significant Other Employer : _____

Gross Annual Salary $_____ Take Home Monthly Income $_____

Other Income $_____

Total Monthly Income $ _____

Assets

This section is to be completed by the patient.

Asset Type	Current	Value	Loan	Income
Home Ownership				
Auto Ownership				
Checking Account				
Savings Account				
Rental				
Other				

Other Funding Resources This section is to be completed by the patient.					
Program	**Date Started**	**Monthly Amount**	**Program**	**Date Started**	**Monthly Amount**
Social Security			**Pell Grant**		
SSI			**Pension**		
SSDI			**Unemployment**		
OAP			**Workman's Comp**		
TANF			**Child Support**		
A.N.D.			**Food Stamps**		
VA			**Other**		

Other Financial Grants or Assistance Pursued This section is to be completed by the patient and/or coordinating social worker or healthcare professional			
Name of Agency	**Assistance Requested**	**Amount**	**Status**

Monthly Household Expenses This section is to be completed by the patient.			
Total Monthly Expenses $_____			
Rent/Mortgage $	Gas/ Electric $	Phone $	Cell Phone $
Water/Sewer $	Cable/Internet $	Auto Payment $	Auto Insurance $
Gas/Oil/Repairs $	Public Transportation $	Health Insurance $	Medical $
Dental $	Pharmacy $	Food $	Entertainment $
Child care / support $	Other $	Other $	Other $

Work Status
This section is to be completed by the patient and/or coordinating social worker or healthcare professional

Unemployed or Work Status Change: If applicant or other household adults are unemployed or had a work status change, please explain why and describe plans for returning to work if possible.

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Requested Assistance

Provide the information below to document the requested funding.
This section must be completed by the assisting social work or healthcare professional.

Patient Services Fund $_____
List total amount requested for this fund.

Medical Transportation Fund $_____
List total amount requested for this fund.

Emergency Distress Fund $_____
List total amount requested for this fund.

Caregiver/Lodging Fund $_____
List total amount requested for this fund.

Total Amount Requested $

List the patient's physicians and other medical providers (physical therapist, prosthetic provider, etc.) **in reference to this request.**

Description of Problem

Describe the medical condition and situation of the applicant. Also explain why he or she is in need of help from The Limb Preservation Foundation.

Assistance Worksheet **This section must be completed by the assisting social work or healthcare professional.**		
Outpatient Chemotherapy: _____ Name of Oncologist:		
Address:		
Phone:	Email:	
# of Treatments:	Amount per Treatment: $	Total:$
Outpatient Intravenous Antibiotics: _____ Name of Physician:		
Address:		
Phone:	Email:	
# of Treatments:	Amount per Treatment: $	Total:$
Outpatient Occupational or Physical Therapy: _____ Name of Physician/Organization:		
Address:		
Phone:	Email:	
# of Treatments:	Amount per Treatment: $	Total:$
Total Request for Patient Services $		
Medical Transportation Fund		
Prepaid Gas Cards	**Amount Requested: $**	
# of Trips in 3 months:	Roundtrip Mileage:	Car (estimated) miles/gallon:
From:	To:	
Other (Bus Ticket, Cab Vouchers, Airline Tickets) Amount Requested: $		
Date of Travel:		
From:	To:	

Emergency Assistance Fund **For all categories an appropriate bill or other documentation must accompany the application (i.e. lease, bill or invoice). The Foundation may limit assistance based on availability of funds.** **Food assistance via prepaid cards will NO LONGER be provided in 2020.**			
Emergency Shelter:			*(up to $1000/month)*
Rent: $	(monthly)	Mortgage: $	(monthly)
Health Insurance Premium:			
Monthly Premium: $	(monthly)	Type of Insurance:	
Utility Assistance:		**(up to $100/month total)**	
(This is limited to gas, electric, water/sewer. Cable TV and monthly phone handset payments will not be covered. Phone data and service plans will be covered.)			
Heat: $	(monthly)	Electricity: $	(monthly)
Water: $	(monthly)	Telephone: $	(monthly)
Car or car insurance payment:			*(up to $500/month)*
What type of assistance is needed:		Amount Needed: $	
Emergency Childcare:		Amount Needed: $	
Other:		Amount Needed: $	
Total Request for Emergency Assistance Fund: $			
Patient/Caregiver Lodging Fund			
Number of days and dates of lodging needed:			
Location where medical treatment is being provided:			
Are you able to cover any of the hotel costs yourself?	No		
Total Request for Patient/Caregiver Lodging Fund: $			*(up to $65/night)*

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Application Declaration and Authorization

I authorize The Limb Preservation Foundation to use this information to assess my eligibility for participation in the Foundation's Patient Assistance Program, including the audit of my medical records and/or by contacting me directly to confirm my eligibility or receipt for matters related to such program. I understand that this assistance is temporary and that this Program may be discontinued or changed at any time. I understand that The Limb Preservation Foundation will use my personal information in connection with the operation of the Program and issues related to such program. I certify I do not have the ability to pay for the assistance requested. I also certify that I do not have other sufficient financial resources or assets to pay for the assistance requested or that paying for the assistance from my own resources or assets would cause me severe financial hardship. I attest the information that I have provided is correct and complete.

I authorize the Supplier of the Program to disclose to The Limb Preservation Foundation all personal information relating to my medical condition, treatment and insurance coverage needed to administer my participation in the Program. I understand that if I refuse to sign this authorization, I will not be able to participate in the Program, but it will not affect my ability to obtain medical treatment, my ability to seek payment for treatment or affect my insurance enrollment or eligibility for insurance benefits. I understand that I may cancel this authorization at any time by mailing a letter to the Program. Canceling this authorization will prohibit disclosures of my personal information after that date the cancellation letter is received and processed but will not affect disclosures made before that time. I understand that once my personal information is disclosed to The Limb Preservation Foundation, federal privacy laws may no longer protect the information from further disclosure. This authorization expires at the end of my participation in the program.

Patient/Legal Guardian/Personal Representative Signature:

Date

Printed Name:

_____

☐ Patient ☐ Legal Guardian/Personal Representative

MSW/Medical Professional Recommendation		
MSW/Medical Professional Name:		
Facility Name:		
Facility Address:		
Contact Phone:		
Contact Email:		
Please attach a Letter of Assessment or comment to this application releasing information pertaining to the visible candidacy of the patient in regard to positive lifestyle choices.		
Does the patient adhere to medical direction?	Yes ☐	No ☐
Does the patient smoke?	Yes ☐	No ☐
Does the patient consume alcohol?	Yes ☐	No ☐
Does the patient use un-prescribed drugs?	Yes ☐	No ☐
To my knowledge, health insurance or other programs will not cover the type of assistance requested above. **MSW / Medical Professional's Signature**		
All information is strictly confidential. Funds are limited and based on availability. Incomplete applications will be returned. Completed applications are reviewed by a committee and will be processed in 2 - 4 weeks.		