THE LIMB PRESERVATION FOUNDATION
Funding Hope, Help and Possibilities

P.O. Box 270530
Littleton, CO 80127
303-429-0688
http://limbpreservation.org
email: PatientResources@limbpreservation.org

Patient Assistance Additional Application

(Additional to original application to be used for additional assistance)

Date of original application: _____ ***Date of additional needs:*** _____

Program Fund(s) Requested with Amounts:

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.

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

Total Amount Requested $

(Please make sure copies of appropriate documentation (i.e. lease, bill or invoice) are accompanied with the request)

Describe why additional assistance is needed, as well as what other resources of funding the patient has applied for: _____

_____

_____

_____

_____

Patient Information:

Name: _____ Age: _____ Phone: _____

Address: _____

City/State/Zip: _____

Update on patient's medical condition: _____

_____

_____

What assistance was given prior to this application?:

Has the patient's or caregiver(s) for the patient's work status or financial information changed from the first application? No

If yes, please describe:

Referring Agency Information

Agency

Contact Phone

Patient's doctor

I certify that the information provided on this application is true and accurate to the best of my knowledge. The applicant and referring agency agree to defend, indemnify and hold The Limb Preservation Foundation harmless from any and all claims, disputes, liabilities or causes of action arising out of the agreement to provide assistance, or the providing of assistance, or arising out of services and goods sold or provided to recipients of assistance through The Limb Preservation Foundation.

Referring Agency Contact Signature:_____ Date_____

Applicant {Guardian} Signature:_____ Date _____

Please note that falsification of any of the above information is grounds for denial of funds, or immediate termination of support upon discovery.

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:	Cost per Treatment: $	Total:$
Outpatient Intravenous Antibiotics:	Name of Physician:	
Address:		
Phone:	Email:	
# of Treatments:	Cost per Treatment: $	Total:$
Outpatient Occupational or Physical Therapy:	Name of Physician/Organization:	
Address:		
Phone:	Email:	
# of Treatments:	Cost 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/s 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)*