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The Limb Preservation Foundation
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Patient Assistance Additional Fund Application

(This application is to be used for additional assistance if a new application was completed previously within a 12 month period)

All Applications must be coordinated by a social worker or healthcare professional. Applications requesting funding that exceed the maximum limitations will not be reviewed.

All fields of the application are required. Please provide explanation on incomplete items.

Date of application: ______ Date of original application: ______

Patient Information

Patient Name: ______

Date of Birth: ______ Age: ______ Gender: ☐ Male ☐ Female

Street Address: ______

City: ______ State: ______ Zip: ______

Phone: ______

Email: ______

Update on patient's medical condition

Additional Assistance Being Requested Check all that apply

Mortgage/Rent ☐ Car or Car Insurance ☐ Utility Bill ☐ Patient/Caregiver Lodging ☐

Outpatient Treatment ☐ Health Insurance Premium ☐

Assistance Worksheet Please make sure the numbers and totals are accurate		
Mortgage/Rent (up to $1,000/month) Mortgage: $	Rent: $	
Car or Car Insurance (up to $500/month) Car Payment: $	Car Insurance: $	
Utility Bill (up to $100/month) Heat: $	Electricity: $	Water: $
Health Insurance Premium (per case) Monthly Premium: $	Type of Insurance:	

Patient/Caregiver Lodging

If the patient would like for The Limb Preservation Foundation to provide lodging, it will be reserved at the preferred lodging location with a rate of **$70 per night**. If the patient would like to stay at another facility, it will be the patient's responsibility to make those reservations and cover the costs. In certain cases (very limited), the Limb Preservation Foundation may be able to cover some of the lodging at $70 per night if the vendor is able to invoice the Foundation. Otherwise, the lodging will be the patient's full responsibility.

Dates lodging is being requested:	Number of nights:
Location of medical treatment:	
Is the patient able to cover any of the hotel costs?	
Total amount requested for lodging: $	

Outpatient Treatment

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/Physical Therapy – Name of Therapist:		
Address:		
Phone:	Email:	
# of Treatments:	Amount per Treatment: $	Total: $
Total amount requested for outpatient treatment: $		

TOTAL AMOUNT REQUESTED FOR ASSISTANCE (Add up all categories): $

The amount of funds available are limited on a month to month basis and will be awarded by the committee based on availability and needs. There is no guarantee of coverage.

What assistance was given prior to this application from The Limb Preservation Foundation?

Has the patient's or caregiver(s) for patient's work status or financial information changed from the previous application?

If "Yes" please describe in detail below:

MSW/Medical Professional Information	
MSW/Medical Professional Name:	
Phone:	Email:
Patient's Treating Physician:	

By signing below, 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 or 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. I also acknowledge that any falsification of information above is grounds for denial of funds and/or immediate termination of support and future assistance.

MSW/Medical Professional Signature: Date:

Patient (Caregiver) Signature: Date: