Revised on 10.2021

The Limb Preservation Foundation
P.O. Box 270530
Littleton, CO 80127
303-429-0688
PatientResources@limbpreservation.org
https://limbpreservation.org

Patient Assistance Fund Application Cover Sheet

This cover sheet must accompany the Assistance Fund Application along with all necessary documents or else the application will not be reviewed.

Checklist of items that must accompany the patient assistance fund application:

☐ Full completed application with signatures

☐ Letter or email of explanation/recommendation from medical professional

☐ Copy of ID for proof of identity

☐ Invoices and/or bills that clearly show the amount and information on where to send payment (if applicable)

Important Notes

✔ Any incomplete applications missing items from the checklist will not be accepted and returned.

✔ Applications submitted directly by the patient/caregiver omitting signed documentation from a medical provider actively treating the patient will be returned and not considered by LPF.

✔ When The Limb Preservation Foundation has tried three attempts to get responses to questions with no answer, the application will be denied.

✔ Applications must be submitted by the 3rd Monday of each month to be considered for the current month's committee review. If it is received after, it will not be reviewed until the next month.

☐ I acknowledge the above disclosures and verify that all items have been completed and supporting documents have been attached to this application.

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Patient Assistance Fund Application

The mission of The Limb Preservation Foudnation is the 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.
All fields of the application are required. Please provide explanation on incomplete items.

Patient Biographical Information

Date of Application: ☐

Patient Name: ☐

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

Street Address: ☐

City: ☐ State: ☐ Zip: ☐

Phone: ☐

Email: ☐

Married or have domestic partner: ☐ Yes ☐ No

Number of children: ☐ ☐ N/A

How many total in household (Explain situation in letter if needed): ☐

Race (check all that apply):

American Indian/Native Alaskan ☐ Caucasian ☐
African American ☐ Hispanic ☐
Asian/Pacific Islander ☐ Other: ☐

Are you a veteran of the US Armed Forces: ☐ Yes ☐ No

Patient Insurance Coverage

Does patient have private health insurance? ☐ Yes ☐ No

If Yes, name of provider:

Annual deductible amount $ Terms:

Does patient have Medicare? ☐ Yes ☐ No

If Yes, does patient have secondary insurance? ☐ Yes ☐ No

Does patient have Medicaid? ☐ Yes ☐ No

Monthly Household Expenses					
Rent/Mortgage		Gas/Electricity		Phone	
Car Payment		Water		Cable/Internet	
Health Insurance		Auto Insurance		Child support/care	
Dental		Gas/Oil/Repairs		Food	
Other		Other		Other	
TOTAL Monthly Expenses: $					

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

Other Funding Resources					
Program	**Monthly Amount**	**Program**	**Monthly Amount**	**Program**	**Monthly Amount**
Social Security		OAP		VA	
SSI		TANF		Pell Grant	
SSDI		A.N.D.		Pension	
Unemployment		Workman's Comp		Child Support	
Food Stamps		Other		Other	

Patient Financial Information

Patient Employer:

Gross Annual Salary: $ Take Home Monthly Income: $

Spouse/Domestic Partner Employer:

Gross Annual Salary: $ Take Home Monthly Income: $

Other Misc Income: $

Total Monthly Income: $

Work Status

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:

Medical Information
List the patient's physicians and other medical providers (physical therapist, prosthetist, etc) in reference to this request:

Description of Problem
Describe the medical condition/diagnosis and situation of the patient. Also explain why he/she is in need of help from The Limb Preservation Foundation.

Requested Assistance
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 is requesting lodging, it will be reserved at the preferred location with a rate of **$70 per night**. If the patient wants to stay at another facility, it will be their responsibility to make those reservations and cover the costs. In very limited cases, 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.

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.

THE LIMB PRESERVATION FOUNDATION

Funding Hope, Help and Possibilities

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.

I certify that the information on this application is true and correct to the best of my knowledge. I understand that any false information will immediately cause this application to become denied and all future applications will not be accepted.

☐ This box must be checked or the application will be declined for review

Patient/Legal Guardian/Personal Representative Signature:

Date:

Printed Name:

Patient: ☐ Legal Guardian/Personal Representative: ☐

MSW/Medical Professional Recommendation

This section is to completed by the MSW or Medical Professional ONLY

MSW/Medical Professional Name:

Facility Name:

Facility Address:

Contact Phone:

Contact Email:

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

Any other information:

Disclosures and Acknowledgments

Please complete the acknowledgments and sign below. The application will be declined for review with missing fields.

To my knowledge, health insurance or other programs will not cover the type of assistance requested above. ☐

I have carefully reviewed and assessed the financial situation of the patient. ☐

I have attached a letter of assessment or will explain in the email, releasing information pertaining to the visible candidacy of the patient in regard to positive lifestyle choices and other information to assist the application. ☐

MSW/Medical Professional's Signature:

Date:

All information is strictly confidential. Funds are limited and based on availability and reviewed on a month to month basis, therefore, the amount approved can vary each month. Incomplete applications will be declined and returned. Please be sure the cover page is included and all copies of vendor bills/invoices are attached as well. Completed applications are reviewed by a committee and will be processed in 2-4 weeks. Please submit completed application and documents to PatientResources@limbpreservation.org