Revised on 1/2023

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 and signed 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 $200/month) Heat: $ _____ Electricity: $ _____ Water: $ _____

Health Insurance Premium (per case) Monthly Premium: $ _____ Type of Insurance: _____

Patient/Caregiver Lodging
If lodging is being requested, it will be reserved at our preferred location at a rate of **$70 per night**.
Any other location will be the patient's full responsibility.

Dates lodging is being requested: _____ Number of nights: _____

Location of medical treatment: _____

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 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.

IMPORTANT: Please be sure to include ALL copies of the most current bills and statements that are being requested for payment. If the name on the bills are not the patient or spouse name, please explain on the bill why or else it will be denied.

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: