



The Limb Preservation Foundation  
P.O. Box 270530  
Littleton, CO 80127  
303-429-0688  
[PatientResources@limbpreservation.org](mailto: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 Monday before the committee meeting. Committee meetings are typically the 3<sup>rd</sup> or 4<sup>th</sup> Thursday of each month. Please check with [PatientResources@limbpreservation.org](mailto:PatientResources@limbpreservation.org) to confirm. If the application is received after the Monday before the meeting, 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 Foundation 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 and signed 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

Spouse or Caretaker's Name:

Number of children (under 18):   N/A Total number in household:

Explain household situation (**Age of each person**, names on bills, why the number of persons living in house, etc):

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

How did you hear about this program (check one):

From my social worker/nurse  From my PT/OT  From my prosthetist

From my doctor  From a friend  Online search  Other:

**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      Does patient have Medicaid?  Yes  No

**Monthly Household Expenses**

Rent/Mortgage	<input style="width: 90%;" type="text"/>	Gas/Electricity	<input style="width: 90%;" type="text"/>	Phone	<input style="width: 90%;" type="text"/>
Car Payment	<input style="width: 90%;" type="text"/>	Water	<input style="width: 90%;" type="text"/>	Cable/Internet	<input style="width: 90%;" type="text"/>
Health Insurance	<input style="width: 90%;" type="text"/>	Auto Insurance	<input style="width: 90%;" type="text"/>	Child support/care	<input style="width: 90%;" type="text"/>
Dental	<input style="width: 90%;" type="text"/>	Gas/Oil/Repairs	<input style="width: 90%;" type="text"/>	Food	<input style="width: 90%;" type="text"/>
Other	<input style="width: 90%;" type="text"/>	Other	<input style="width: 90%;" type="text"/>	TOTAL Monthly Expenses:	<input style="width: 90%;" type="text"/>

**Assets**

Asset Type	Value	Loan	Asset Type	Value
Home Ownership	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	Checking Account	<input style="width: 90%;" type="text"/>
Auto Ownership	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	Savings Account	<input style="width: 90%;" type="text"/>
Other	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	Other	<input style="width: 90%;" type="text"/>

**Other Funding Resources**

Program	Monthly Amount	Program	Monthly Amount	Program	Monthly Amount
Social Security	<input style="width: 90%;" type="text"/>	SSI	<input style="width: 90%;" type="text"/>	SSDI	<input style="width: 90%;" type="text"/>
Unemployment	<input style="width: 90%;" type="text"/>	Child Support	<input style="width: 90%;" type="text"/>	Rental Income	<input style="width: 90%;" type="text"/>
Food Stamps	<input style="width: 90%;" type="text"/>	Other	<input style="width: 90%;" type="text"/>	Other	<input style="width: 90%;" type="text"/>

**Patient Financial Information**

Patient Employer:

Gross Annual Salary: \$       Take Home Monthly Income: \$

Spouse/Domestic Partner/Caretaker Employer:

Gross Annual Salary: \$       Take Home Monthly Income: \$

Other Misc Income: \$

Total Monthly Income From All Sources: \$

**Patient Work Status**

Give a clear and complete explanation on work statuses of patient, spouse, domestic partner or caretaker as applicable to your situation:

**Patient Medical Provider(s)**

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

**Patient Medical Information**

Describe the medical condition/diagnosis and situation and why patient is in need of help from the Limb Preservation Foundation.  
(This is separate from the medical provider letter/email.)

**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 \$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.***



### 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:

<b>MSW/Medical Professional Recommendation</b> <i>This section is to completed by the MSW or Medical Professional ONLY</i>	
MSW/Medical Professional Name:	<input type="text"/>
Facility Name:	<input type="text"/>
Facility Address:	<input type="text"/>
Contact Phone:	<input type="text"/>
Contact Email:	<input type="text"/>
Were allografts and/or donated human tissue used in the treatment of this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient adhere to medical direction? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any other information: <input type="text"/>	
<b>Disclosures and Acknowledgments</b> <i>Please complete the acknowledgments and sign below. The application will be declined for review with missing fields.</i>	
To my knowledge, health insurance or other programs will not cover the type of assistance requested above. <input type="checkbox"/>	
I have carefully reviewed and assessed the financial situation of the patient. <input type="checkbox"/>	
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. <input type="checkbox"/>	
MSW/Medical Professional's Signature:	<input type="text"/>
	Date: <input type="text"/>
<i>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 <a href="mailto:PatientResources@limbpreservation.org">PatientResources@limbpreservation.org</a></i>	