The Limb Preservation Foundation
1721 E 19th Avenue, Suite 106
Denver, CO 80218
303-429-0688

Patient Assistance Application

(Revised 2/2017)

The mission of The Limb Preservation Foundation is to 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.

Client Biographical Information

This section is to be completed by the patient.

All fields are required. Please provide explanation for incomplete items.

Date of Application: ____________________ Date of Birth:________________________

Patient Name:____

Address:____

City:___________________________________ State:________________ Zip:______________

Cell Phone: ____________________________ Home Phone: ____________________________

Email Address:____

Age:________________ Gender: _________ Male __________ Female

Race:

_____ 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

This section is to be completed by the patient and/or coordinating social worker or healthcare professional.

Does Patient have Private Health Insurance? ______ Yes ______ No

Name of Provider: ____

Annual Deductible Amount $_______________Terms_______________________________

Does Patient have Medicare? ______ Yes ______ No

If you receive Medicare do you have a secondary Insurance ______ Yes ______No

Does Patient have Medicaid? ______ Yes ______ No

Patient Financial Information

Patient Employer:____

Gross Annual Salary $_____________ Take Home Monthly Income $____________

Spouse/Significant Other Employer : ____

Gross Annual Salary $_____________ Take Home Monthly Income $____________

Other Income $____

Total Monthly Income $ _____________________

Assets

This section is to be completed by the patient.

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

Other Funding Resources This section is to be completed by the patient.					
Program	Date Started	Monthly Amount	Program	Date Started	Monthly Amount
Social Security			Pell Grant		
SSI			Pension		
SSDI			Unemployment		
OAP			Workman's Comp		
TANF			Child Support		
A.N.D.			Food Stamps		
VA			Other		

Other Financial Grants or Assistance Pursued This section is to be completed by the patient and/or coordinating social worker or healthcare professional			
Name of Agency	Assistance Requested	Amount	Status

Monthly Household Expenses This section is to be completed by the patient.			
Total Monthly Expenses $____________			
Rent/Mortgage $	Gas/ Electric $	Phone $	Cell Phone $
Water/Sewer $	Cable/Internet $	Auto Payment $	Auto Insurance $
Gas/Oil/Repairs $	Public Transportation $	Health Insurance $	Medical $
Dental $	Pharmacy $	Food $	Entertainment $
Child care / support $	Other $	Other $	Other $

Work Status This section is to be completed by the patient and/or coordinating social worker or healthcare professional
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.

Requested Assistance Provide the information below to document the requested funding. This section must be completed by the assisting social work or healthcare professional.
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. **Caregiver/Lodging Fund $**_______________ List total amount requested for this fund. **Total Amount Requested $**_______________________________________
List the patient's physicians and other medical providers (physical therapist, prosthetic provider, etc.) **in reference to this request.**
Description of Problem
Describe the medical condition and situation of the applicant. Also explain why he or she is in need of help from The Limb Preservation Foundation.

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:	Amount per Treatment: $	Total:$
Outpatient Intravenous Antibiotics: ________	Name of Physician:	
Address:		
Phone:	Email:	
# of Treatments:	Amount per Treatment: $	Total:$
Outpatient Occupational or Physical Therapy: ________	Name of Physician/Organization:	
Address:		
Phone:	Email:	
# of Treatments:	Amount per Treatment: $	Total:$
Total Request for Patient Services $____________________		
Medical Transportation Fund		
Prepaid Gas Cards	**Amount Requested: $**	
# of Trips in 3 months:	Roundtrip Mileage:	
From:	To:	
Other (Bus Ticket, Cab Vouchers, Airline Tickets) Amount Requested: $		
Date of Travel:	Travel #s:	
From:	To:	

Emergency Assistance Fund **For all categories an appropriate bill or other documentation must accompany the application (i.e. lease, bill or invoice).**		
Emergency Shelter: ________		
Rent: $ (monthly)	Mortgage: $ (monthly)	
Health Insurance Premium:___________		
Monthly Premium: $ (monthly)	Type of Insurance:	
Utility Assistance: ________		
Heat: $ (monthly)	Electricity: $ (monthly)	
Water: $ (monthly)	Telephone: $ (monthly)	
Additional Medical Care: ________		
What type of care is needed:	Amount Needed: $	
Emergency Childcare: ________	Amount Needed: $	
Other:	Amount Needed: $	
Total Request for Emergency Assistance Fund: $		

Patient/Caregiver Lodging Fund
Number of days of lodging needed:
Location where medical treatment is being provided:
Are you able to cover any of the hotel costs yourself?
Total Request for Patient/Caregiver Lodging Fund: $

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.

Patient/Legal Guardian/Personal Representative Signature:

____________________________________ Date______________________

Printed Name:

____

_____ Patient _____ Legal Guardian _____ Personal Representative

MSW/Medical Professional Recommendation		
MSW/Medical Professional Name:		
Facility Name:		
Facility Address:		
Contact Phone:		
Contact Email:		
Please attach a Letter of Assessment or comment to this application releasing information pertaining to the visible candidacy of the patient in regard to positive lifestyle choices.		
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______
To my knowledge, health insurance or other programs will not cover the type of assistance requested above. **MSW / Medical Professional's Signature**____		
All information is strictly confidential. Funds are limited and based on availability. Incomplete applications will be returned. Completed applications are reviewed by a committee and will be processed in 2 - 4 weeks.		