



Funding Hope, Help and Possibilities

The Limb Preservation Foundation

925 S Niagara Street, Suite 610

Denver, CO 80224

303-429-0688

Patient Assistance Application

(Revised 2/2018)

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.



Funding Hope, Help and Possibilities

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



Funding Hope, Help and Possibilities

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.		