Patient Assistance Application Instructions

Are you eligible for financial assistance through Limbs for Life (LFL)?

- You must be a lower limb amputee who has no other means to pay for prosthetic care including: Medicaid, Medicare, insurance coverage or state assistance (LFL does not assist with co-pays or co-insurance)
- You must be a U.S. citizen or a legal permanent resident of the U.S. to qualify
- You must show proof of your financial need by providing verification of monthly income
- You must consent to a criminal background check (p. 3)
- You must use a prosthetist that agrees to accept LFL payment as full payment for their services (p. 4)

How to apply

- When submitting your application you must include these items:
  - A readable copy of your photo ID; if you are not a U.S. Citizen, a copy of your Permanent Residence Card or Naturalization Certificate is required
  - Monthly federal aid notices: SS/SSI/SSDI award letters & food stamp statements (Include spouse)
  - If you or your spouse are working, send copies of pay stubs to show most recent income
  - If you don’t have any income and someone is supporting you, please have them write a letter on your behalf stating they are currently helping you out with shelter, bills, etc.
  - Return required copies by mail, fax or email to:

Limbs for Life Foundation
9604 N. May Ave., Oklahoma City, OK 73120
Fax 405-843-5123 or admin@limbsforlife.org

- If you have not received any contact from Limbs for Life within 30 days of submitting your application, please contact us at 888-235-5462 or admin@limbsforlife.org.

- Our minimum waiting period is 90 – 120 days following receipt of your complete application and all required documents. Other available state resources should be pursued during this time.

Limbs for Life is not able to fund all applicants. These factors are considered during application review:

- financial need
- U.S. residency status
- criminal background
- physical health and well-being
- anticipated mobility outcome
- self-motivation

Approved applicants:

- Will receive a call confirming that your funds are available and you may now make an appointment with your prosthetist to begin the fitting process
- A confirmation letter is faxed to your prosthetic clinic
- Limbs for Life’s commitment will expire six months (6) from the date of confirmation

It is your responsibility to notify us with any changes in your contact information. Please note: complete applications with all required documentation will be given priority in the application process.
ADULT APPLICANT INFORMATION
(Complete blanks or circle correct response)

Last Name_____________________________First Name_____________________________Middle________________

Marital Status__________________________Gender:  M  or  F  Maiden Name________________________

Date of Birth___/___/___ SSN (required for background check)________________________

Ethnicity/Race:  Black/African American White  American Indian

Asian  Hispanic/Latino  Other________________________

US Citizen? Have you received funding from LFL in the past? ________ Year? ________

Address________________________

City__________________________State______________Zip________________________

Phone____________________2nd Phone____________________Email____________________

Alternate Contact____________________Phone____________________

Limbs for Life provides financial assistance for individuals who have no insurance, no government
or supplement assistance that covers any portion of the cost of prostheses. A client receiving any
form of assistance for any payment for prosthetics does not qualify for funding from Limbs for Life.

Are you currently employed?    Yes or No    If not, do you plan to return to work or school?    Yes or No

What is your occupation?________________________

Have you contacted your state vocational rehabilitation agency about the availability of help? Yes or No

Do you receive assistance from or are you covered by any of the following (circle all that apply):
Medicaid   Medicare Part B   Social Security Disability   Social Security   Health Insurance
Monthly Income $________________________Spouse Income $________________________

Food Stamps   $________________________Other $________________________

*You must submit copies of your photo ID, SSI/SSDI & Food Stamp statements, pay stubs, or bank
statements as proof of household income (incl. spouse). If you don’t receive any income then we
require a letter of support from someone who knows your situation or is helping you out.

Are you responsible for care of children under the age of 18? Yes or No    # of children in your care__________

Living arrangements:  Rent  Own  Reside with friend or relative  Long Term Care Facility

How did you hear about Limbs for Life?  Internet  Social Worker  Doctor/Hospital  Clinic

Other________________________

I verify that the above information is true to the best of my knowledge, and understand that this information will be kept
confidential.

Patient Signature________________________Date:________________________
MEDICAL INFORMATION

Applicant Name:________________________

Do you have a prescription for your prosthesis? Yes or No

Circle Level of Limb Loss: Right Above Knee  Left Above Knee  Right Below Knee  Left Below Knee

Do you currently wear a prosthesis? Yes or No  How long have you had it? _______________________

Circle cause of limb loss or list other

Congenital  Cancer  Diabetes  Gangrene  Infection  Injury/Trauma  Vascular Disease

Other   ____________________________________________

Describe details/circumstances of your limb loss:

_________________________________________________________

_________________________________________________________

_________________________________________________________

Date of Amputation (month/year) __________

Do you have Diabetes? Yes or No  List other health problems _______________________

_________________________________________________________

Excluding the amputation, circle the number that best rates your overall health

1  2  3  4  5  6  7  8  9  10
(Poor) (Excellent)

How will a new prosthetic leg improve the quality of your life and the lives of your family members? List all hobbies, activities, or particular lifestyle details. Please be detailed and use another page if needed:

_________________________________________________________

_________________________________________________________

_________________________________________________________

Please list any immediate circumstances we need to be aware of:

_________________________________________________________

_________________________________________________________

_________________________________________________________

I verify that the above information is true to the best of my knowledge, and understand that this information will be kept confidential.

Patient Signature: _____________________________ Date: _____________________________
LIMBS FOR LIFE FOUNDATION
APPLICANT’S CONSENT FOR BACKGROUND CHECK,
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND RELEASE OF CLAIMS
(NOTE: photo release is the only optional item)

By signing below I agree to authorize the following:

- I have applied to Limbs for Life Foundation for financial assistance in obtaining a prosthesis and/or related services. I acknowledge that if financial assistance is awarded on my behalf, Limbs for Life Foundation’s involvement is limited to providing financial assistance with payment to the clinic and not the individual. Limbs for Life Foundation does not provide prostheses or any related services. Limbs for Life Foundation has not made any guarantees, warranties or assurances to me regarding the prosthesis or related services.
- I hereby give my permission to Limbs for Life Foundation to obtain information relating to my employment records, educational verification, license verifications, driving history, previous address, social security verification, and public records relative to criminal charges and criminal history. I understand that this information will be used, in part, to determine my eligibility for financial assistance to obtain prosthetic care.
- I understand that my application to Limbs for Life may be denied because of information contained in this report and any adverse information could have effect, repercussions, or consequences in my efforts to obtain assistance from Limbs for Life.
- I authorize the holder of any medical documentation or information about me to release to Limbs for Life Foundation any information needed to determine if I qualify for financial assistance according to the conditions of Limbs for Life Foundation.
- I do hereby completely release, acquit, hold harmless, and forever discharge Limbs for Life Foundation and its agents, affiliates, servants, employees, principals, successors, divisions, groups, subsidiaries, affiliates, affiliated companies, branches, shareholders, predecessor companies, successor companies, officers or directors, (it being agreed that it is not necessary to specifically name each and every one of them) of any and all responsibility, present or future claims, suits, obligations, liabilities, causes of action, demands, damages, costs and expenses of any nature whatsoever, known or unknown, in law, equity or otherwise, which I now have or which may hereafter accrue on account of, result from, or in any way arise out of or in connection with, the prosthesis and related services. This Release shall be binding upon the executors, administrators, personal representatives, heirs, successors, and assigns of the undersigned.

I acknowledge that I have read and fully understand this Release, Authorization, and Consent and that all my questions regarding same have been answered to my satisfaction.

Patient Signature (required): ___________________________ Date: ___________________________

PHOTO/VIDEO/MEDIA RELEASE (optional)

I give my consent to Limbs for Life to use any photographs, video, or any other medium taken of me for educational and/or publication purposes.

Patient Signature: ___________________________ Date: ___________________________
PROSTHETIST INFORMATION
To be completed and signed by the prosthetist

Prosthetist Name: _______________________________ Certification Type: __________

Name of Clinic: ________________________________________________________________

Address: ___________________________________________ City/State/Zip __________

Phone (___) __________ Fax (___) __________ Email ______________________________

Applicant Name: ______________________________________________________________

Height ___________ Weight ________________

Level of Amputation: Right Above Knee Left Above Knee Right Below Knee Left Below Knee

Date of Amputation: __________ Cause: __________________________________________

Anticipated Level of Ambulation: K0 K1 K2 K3 K4

Level of Motivation: 1 (lowest) 2 3 4 5

Comments: _______________________________________________________________

______________________________

FEE SCHEDULE

Fee includes test and final socket, fabrication of prosthetic and adjustments as needed for the life of the socket

<table>
<thead>
<tr>
<th>Above Knee, Knee Disarticulation and Hip Disarticulation</th>
<th>$3,500.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below Knee and Symes</td>
<td>$2,500.00</td>
</tr>
</tbody>
</table>

- Limbs for Life (LFL) will provide donated/used componentry, new textile items and replacement parts as needed & as available upon your request
- LFL will not pay for work completed prior to your receipt of the confirmation letter stating approval of our financial commitment
- All work must be completed within six (6) months of the date of the confirmation letter
- LFL will not pay in combination with or supplement any other financial assistance or coverage
- Patient is eligible to re-apply for LFL financial assistance once every 36 months

REQUIRED PRIOR TO PAYMENT

When final limb is delivered, submit a ‘private pay’ invoice with two (2) or more digital photographs and/or video of the patient wearing the new prosthesis.

This agreement, if approved by the Board of Directors, is an agreement between the Foundation and the prosthetic clinic. No money shall ever be paid to the applicant. Additionally, by signing this form, the prosthetist agrees to absorb any additional costs above the amount designated in the fee schedule, so as to provide this service free-of-charge for the applicant.

Prosthetist Signature: _______________________________ Date: __________________

Return this page to:
Limbs for Life Foundation 9604 N. May Ave. Oklahoma City, OK 73120
Toll free: 888-235-5462 Fax: 405-843-5123 admin@limbsforlife.org Ver. 2020.1