Limbs for Life
9604 N. May Ave.
Oklahoma City, OK 73120
(405) 843-5174 office / (405) 843-5123 fax
(888) 235-5462 toll-free
www.limbsforlife.org

KEEP INSTRUCTIONS & FAQS FOR FUTURE REFERENCE

Patient Assistance Application Instructions - CHILD

- Review Frequently Asked Questions to assure that you are eligible for assistance (over)
- Fill out all forms completely, including required signatures. If something does not apply to you, indicate N/A
- Before completing application, consult with a clinic/prosthetist for an initial evaluation. Clinic/prosthetist must complete and sign sections of the application as well
- **Incomplete Applications Will Delay the Approval Process**

When completed:

- Mail, email or fax application and copy of readable identification - current state-issued Driver's License or Identification Card OR Permanent Resident Card, if not U.S. citizen to:

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

If guardian is applying for a minor child, include a copy of guardianship documentation.

Upon receipt of completed application, Limbs for Life Foundation will:

- Review information
- Conduct a criminal background check
- Notify patients if they qualify for financial assistance

When the funds become available:

- Patient will receive a call to confirm that prosthetic work may begin at this time
- Confirmation letters mailed to prosthetic clinic and to patient

Limbs for Life will not pay charges incurred before the confirmation letter has been issued, including being fitted or ordering componentry

Limbs for Life's commitment will expire 6 months from the date of the confirmation letter

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FREQUENTLY ASKED QUESTIONS

1. Am I eligible for assistance through Limbs for Life?

   - Limbs for Life (LFL) provides assistance for amputees with Lower Limb Loss. If funds are available, upper limb loss will be considered for minor child.
   - Applicant must be a U.S. citizen or a permanent resident of the U.S.
   - Applicant must have no other means to pay for prosthetic care including Medicare, insurance coverage or state assistance
   - Applicant must work with a prosthetist or clinic that agrees to accept LFL payment as full payment for their services

2. How do I locate a prosthetic clinic that will accept LFL payment?

   - Ask your selected provider to review the application and determine if they will agree to work within the LFL requirements; ask your clinic to call LFL for more information about our application process
   - LFL maintains a list of clinics that have worked with our clients in the past. View the list at limbsforlife.org or call 1-888-235-5462 for referrals in your area

3. How do I apply for assistance?

   - Complete the application and have your prosthetist or clinic complete their sections as well
   - Include a readable copy of your photo ID (If not a US citizen, you must send a copy of your Permanent Resident Card
   - Send application and photo ID to Limbs for Life Foundation by mail, email or fax

4. How long will it take to get my new leg?

   - Once your complete application is received, background check and review can take 3 days to two weeks
   - Applicants with felonies will be reviewed by an advisory committee which meets every 4-6 weeks
   - Once approved, you will be moved to the Waiting List until funds are available. This may take as long as six (6) months

5. What if I move or change my prosthetist before I receive my limb?

   - Contact the LFL office with your updated information

   - Your new prosthetist will need to complete the prosthetist portion of the application form; a new confirmation letter will be issued to the new prosthetist

6. What if I gain other coverage for my prosthetic care prior to receiving confirmation from LFL?

   - Notify the LFL office as soon as possible so that the funds can be used to help another amputee

7. I have other questions.

   - Call the Limbs for Life office between 9:00 a.m. and 5:00 p.m., Central Time at 1-888-235-5462 or email admin@limbsforlife.org. LFL staff is here to answer your questions!

APPLICANT INFORMATION for person under 18 years of age

Last Name:_____ First Name:_____ Middle:_____

Date of Birth:_____/_____/_____ SSN:_____ Gender: M___ F___

Ethnicity: African American ___ Asian ___ Caucasian___ Hispanic___ Multiracial___ Native American___ Other___

U.S. Citizen? _____ or Permanent Resident of the U.S.?_____ [*Provide copy of Permanent Resident Card*]

Mailing Address:_____

City:_____ State:_____ Zip:_____

Parent or Legal Guardian Information

Parent or Legal Guardian Name_____
(Circle One)

Permanent Mailing Address:_____

City:_____ State:_____ Zip:_____

Home Phone :_____ Cell:_____ Work :_____

Email Address:_____

Who may we call if you are unavailable?_____ Phone:_____

Occupation:_____ Employer: _____

Monthly Employment Income:$_____ Other Income:$_____

Do you receive assistance from or are you covered under any of the following (circle all that apply):

Medicare Social Security Disability Social Security Food Stamps

Health Insurance (group or individual) Provide Name and Policy #_____

Community, State and/or Federal Assistance (describe): _____

_____

If you have applied for any of the above or any other financial assistance, describe type and status of application:_____

If you receive disability assistance of any kind, describe your qualifying disability:_____

_____

Is any other person or entity legally responsible for patient's medical bills (e.g. Title XIX, local government assistance programs, guardian, other insurance programs, etc.)? If YES, list:_____

_____

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

Parent/Guardian Signature:_____ Date:_____

Clinic Signature:_____ Date:_____

MEDICAL INFORMATION

Applicant Name:_____

Current Prosthetist/Clinic _____

Name and phone number of Current Physician:_____

Circle Level/Location of Lower Limb Loss:

Above Knee Right Above Knee Left Below Knee Right Below Knee Left

Is limb loss congenital? Yes_____ If not congenital, complete the box below:

Date of Amputation:_____Cause for limb loss (circle all that apply)

Vascular Diabetes Blockage Infection Cancer Frost Bite Circulatory Injury/Trauma Other

If trauma or injury, describe details, cause(s) and circumstances surrounding amputation/loss of limb: ____

_____

_____

_____

Name of hospital, city, state where amputation was performed: _____

_____

*Other conditions or health problems (Check all that apply)

Cancer _____
Heart Disease _____
Anemia _____
Allergies _____
Arthritis _____
Other (Describe)_____

Diabetes _____
High Blood Pressure _____
Kidney Disease _____
Asthma _____
Tuberculosis _____

Epilepsy _____
Stroke _____
Glaucoma _____
Mental Illness _____
Alzheimer's _____

How did you hear about Limbs for Life Foundation?

Doctor/Clinic Referral_____ Internet_____Social Worker_____ Other_____

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

Parent/Guardian Signature:_____Date:_____

PROSTHETIST INFORMATION
To be completed by the prosthetist and patient or guardian

FEE SCHEDULE

Type	Maximum Payment by Limbs for Life Foundation
Above Knee, Knee Disarticulation, and Hip Disarticulation	**$3,500.00**
Below Knee and Symes	**$2,500.00**

- Limbs for Life (LFL) will not pay in combination with or supplement any other financial assistance
- LFL will not pay for any work done prior to prosthetist receiving letter of confirmation stating the maximum amount of Limbs for Life financial commitment
- LFL will not pay for any additional costs of repairs or supplies
- Adults are eligible to re-apply for a new prosthesis once every 3 years
- Children may apply once each year until the age of 18
- Clients should not be billed for any prosthetic expense
- All work must be completed within six months of confirmation letter date or patient must re-apply
- Prosthetist should provide LFL with Patient Intake Form and/or Initial Evaluation Form – Fax to 405-843-5123 or email to admin@limbsforlife.org
- With the invoice, prosthetist will provide LFL with two (2) or more photographs and/or video of the patient wearing the new prosthesis

Applicant Name:_____

Prosthetist Name:_____

Name of Facility/Clinic:_____

Facility Address:_____

Facility Phone #:(_____)_____ Fax #:(_____)_____

Prosthetist Email:_____

Certification Type:_____ Certification #:_____ No. of years in business:_____

Patient's Level of Amputation: (Please circle all that apply)

Above Knee Right Above Knee Left Below Knee Right Below Knee Left

Reason for Amputation (If trauma, list details, cause, etc):_____

_____

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:**_____

Parent/Guardian Signature:_____ **Date:**_____

LIMBS FOR LIFE FOUNDATION
PARENT OR GUARDIAN'S CONSENT FOR BACKGROUND CHECK,
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND RELEASE OF CLAIMS,

Initial each item that you agree to authorize (NOTE: *The photo release is the only optional item*):

_____ 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.

PHOTO/VIDEO/MEDIA RELEASE

_____ 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.

_____ 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 I have had any and all questions I have regarding same answered to my satisfaction.

Parent/Guardian Signature:_____ **Date:**_____