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 FOR FUTURE REFERENCE

Patient Assistance Application Instructions

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

- You must be a lower limb amputee who has no other means to pay for prosthetic care including Medicare, insurance coverage or state assistance (LFL does not assist with co-pays)
- You must be a U.S. citizen or a legal permanent resident of the U.S.to apply
- You must show proof of your financial need
- 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

How to apply

- Complete Pages 1-3 of the application and have your prosthetist complete Page 4
- When submitting your application you must include copies of these items:
  - A readable copy of your photo ID; if you are not a U.S. Citizen, **a copy of your Permanent Residence Card is required**
  - Proof of monthly financial income (copies of federal aid notices – SSI/SSDI/Food stamps)
  - If you do not receive federal or state aid, send copies of pay stubs, bank statements or tax return to show most recent income for you and your spouse (if married)
  - 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, contact us at 888-235-5462 or admin@limbsforlife.org

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 to confirm that LFL will pay for your prosthesis and that 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 stay in contact with us by mail, telephone, fax, or email. Notify us with any change in your contact information. If we cannot reach you, the application process will be delayed. Please call to verify receipt of application.

Questions? Call Limbs for Life at 888-235-5462, M – F, 9 am to 5 pm, CT

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?_____ If not, include *copy of:* ***Permanent Resident Card or*** *Naturalization Certificate*

Address_____

City_____ State_____ Zip_____

Phone_____ 2nd Phone_____ Email_____

Alternate Contact_____ Phone_____

It is your responsibility to stay in contact with us by mail, telephone, fax, or email. Notify us immediately with any change in your contact information. If we cannot reach you, your application will be delayed.

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? **Yes or No**

What was your occupation prior to your limb loss? _____

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

Monthly Income $_____ Spouse Income $_____

Food Stamps $_____ Other $_____

You must submit copies of your photo ID, SSI/SSDI & Food Stamp statements, pay stubs, bank statements, or most recent income tax return as proof of household income (incl. spouse).

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**

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/Clinic Referral**

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 prosthetic? **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 _____

_____

_____

Circle the number that best rates your overall health with 1 = Poor and 10 = Excellent

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 any hobbies, activities, or particular lifestyle details:

_____

_____

_____

_____

_____

_____

_____

_____

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

Above Knee, Knee Disarticulation and Hip Disarticulation	**$3,500.00**
Below Knee and Symes	**$2,500.00**

- Limbs for Life (LFL) will provide donated/used componentry, new textile items and replacement parts **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*:_____**