LIMBS FOR LIFE APPLICATION

218 E. Main St.
Oklahoma City, OK 73104
(405) 605-5462 office / (405) 843-5123 fax
(888) 235-5462 toll-free
www.limbsforlife.org

INSTRUCTIONS

Please fill out all of the following forms thoroughly. You are free to have someone assist you with this application, if necessary. Please have a prosthetist of your choice review, fill out, and sign the Patient and Prosthethist Agreement (page 5). Once the entire packet is completed, mail it back to Limbs for Life at the above address. Please keep this first page for your records.

When we receive your application, a criminal background check is conducted. This step is taken in order to verify that you fit the following criteria:

1. Legal resident of the United States
2. No felony in criminal history (misdemeanors will be taken in front of the board for review)

Approved applications are then confirmed based on the date of submission. We will send a letter to you and your prosthetist informing you that you have been approved for financial assistance. If you fail to meet either one of these criterion, you will be notified by letter.

*One very important detail is that Limbs for Life does not and will not commit to paying any charges incurred *before* an applicant has been confirmed and notified by mail. Consequently, if an individual desires to obtain a prosthesis, components, or funding through Limbs for Life, they must wait for confirmation before incurring charges, such as being fitted or ordering componentry.

All information submitted in this application is strictly confidential and will be used only for the selection process.

All forms must be signed and dated. Blank or missing information on the application is considered to be incomplete. Incomplete applications will not be considered. The application must be completed in its entirety.

— You and your prosthetist have *signed and dated* the Patient and Prosthetist Agreement
— You and your witness have *signed and dated* the Applicant's Release of Claims
— You have *signed* the Photo/Video/Media Release.
— You have *signed* the Consumer Request for Procurement of a Consumer Report page.
— You have supplied a valid social security number.
— You have attached photos. (Full Body shot and copy of Driver's License)
— You have attached copies of your IRS Federal and State Tax Returns for the last two years. (If you did not file, please note)
— On a separate sheet of paper list all medications which you are currently taking.
— On a separate sheet of paper, please describe your current physical and financial situation. Include details about how your amputation affects your life and how you would benefit from a prosthesis.

PROSTHETIST INFORMATION

In order for Limbs for Life to fulfill its mission of providing prosthetic care to amputees in need, there must be a combined humanitarian effort from the foundation, the prosthetist, and the clinic. This is accomplished by Limbs for Life reimbursing the clinic up to the maximum amount in the fee schedule. We are able to provide our services at these costs for two reasons: the prosthetic facility donates their labor and we provide componentry that is donated to us.

Upon receiving a confirmation letter, approved applicants may begin the fitting process. Prosthetists may request componentry for the patient using our Componentry Request Form by emailing **admin@limbsforlife.com**. Please place *Componentry Request Form* in the subject line of the email. Componentry requests will be filled based on available inventory.

Please review the schedule below and fill out the following Patient & Prosthetist Agreement. If you have any questions, please contact the foundation at (405) 605-5462.

LIMBS FOR LIFE PROPOSED FEE SCHEDULE

Type	Materials & Fitting	*Repairs & Adjustments	Total
Upper Extremity	$ 2,000.00	$ 500.00	$ 2,500.00
Hip Disarticulation	$ 2,000.00	$ 500.00	$ 2,500.00
Above Knee	$ 1,500.00	$ 500.00	$ 2,000.00
Below Knee	$ 1,250.00	$ 250.00	$ 1,500.00

*Repairs and adjustments will be covered for the first 6 months after the patient takes delivery of the prosthesis. The Foundation will not reimburse more than is allowed on the above fee schedule. In accordance with Limbs for Life Foundation By-Laws, a patient may receive assistance once in a 36 month period. These guidelines are set so that the foundation can assist as many amputees as possible.

Socket Replacement

For recent amputees receiving a temporary limb there will be an additional reimbursement for the first socket change. The fee schedule is as follows:

Below knee	$250.00
Above knee	$500.00
Below elbow	$250.00
Above elbow	$500.00

GENERAL INFORMATION (Circle one) MR. MRS. MS.

Applicant Name ____________________________________ Date of Birth ____/____/___

SS# ____________________ Are you a legal resident of the US? (Circle One) Yes No

Nationality: (Check One) ___African American ___Asian ___Caucasian ___Hispanic

___Multiracial ___Native American ___Other

Address ____

City __________________________________State _______ Zip _____________________

Home Phone # (____)___________________Work Phone # (_____)__________________

Cell Phone# (____)______________________ Email Address:_______________________

My level of amputation is: (Circle all that apply) Right Left

Below knee(BK) Above knee(AK) Below elbow(BE) Above elbow(AE) other

Please indicate if there is more than one extremity involved_______________________

EMPLOYMENT INFORMATION (Applicant, Parent, or Legal Guardian)

Employer (Company) Name____

Employer Address ____

City __________________________________State _______ Zip _____________________

Work Phone # (___)__________________

How long have you been employed at this job? ______________________

Spouse's Name____

Spouse's Employer _______________________________Phone(___)_______________

Employer Address ____

City __________________________________State ________Zip ___________________

IF MINOR

Parent's Name or Legal Guardian __________________________ SS# ______________

Home Address ____

City __________________________________State ________Zip ___________________

Home Phone # (_____) __________________Cell Phone # (______) ________________

LIMBS FOR LIFE FOUNDATION
APPLICANT'S RELEASE OF CLAIMS

I have applied to the Limbs for Life Foundation ("Foundation") for financial assistance in obtaining a prosthesis and /or related services. I acknowledge that, if the Foundation awards financial assistance on my behalf, the Foundation's involvement is limited to providing financial assistance to the clinic and not the individual. The Foundation does not provide prostheses or any related services. The Foundation has not made any guarantees, warranties or assurances to me regarding the prosthesis or related services.

I do hereby and for my heirs, executors, administrators and assigns, release acquit, hold harmless, and forever discharge the Foundation and its agents, employees, directors, and officers (it being agreed that it is not necessary to specifically name each and every one of them) of any and all responsibility, claims, suits, obligations, liabilities, causes of action, demands, damages, costs and expenses 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.

I acknowledge that I have read and fully understand this Release and the application and that I have had any and all questions I have regarding this Release answered to my satisfaction.

______________________________	______________________________
Applicant signature	**Date**
______________________________	______________________________
Witness	Parent(s)/Guardian (if applicable)

PHOTO/VIDEO/MEDIA RELEASE

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

Patient Signature___________________________ Date_______________________

PATIENT AND PROSTHETIST AGREEMENT

For this application to be considered, the patient and Prosthetist must sign and date the form below. This agreement, if approved by the Board of Directors, is an agreement between the Foundation and 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.

CURRENT PROSTHETIST INFORMATION

Applicant Name ____

Prosthetist Name ____

Name of Facility ____

Facility Address ____

City_______________________________ State ___________ Zip ______________

Facility Phone #(_____)__________________Fax#(_____)______________________

Prosthetist Email ____

Certification Type_______________________ Certification #___________________

Number of years in patient care _________ Number of years in business ___________

The signatures below indicate the prosthetist and patient understand that the Limbs for Life Foundation will reimburse the clinic based upon the fee schedule, if the Board of Directors approves the patient's application. It is understood that any charges incurred above the amount in the fee schedule are the responsibility of the clinic, not the patient or the Limbs for Life Foundation. *<u>**The Limbs for Life Foundation will not be responsible for payment after 12 months from date of approval.**</u>*

Prosthetist Signature________________________ **Date**_______________________

Patient Signature___________________________ **Date**_______________________

BEFORE & AFTER PHOTOGRAPHS

Please submit photographs of the recipient with this application **and** with the invoice after delivery of the prosthesis. These pictures may be used for media purposes. Simply email 3 - 4 digital photos to admin@limbsforlife.org. Pictures should include a full body shot in appropriate clothing where the limb is visible. Please take a picture with and without the prosthesis.

INSURANCE INFORMATION

Insured Person ____

Insurance Company _________________________________Phone # (______)__________

Employer (if group coverage) ____

Policy # ______________________ ID #________________ Group # __________________

2nd Insurance Company ______________________________ Phone # (_____)__________

Explain why Insurance is not paying ____

Have you applied for financial aid through other organizations? Circle one. Yes No

If yes, Where? ________________________ Were you denied? Circle One. Yes No

Please write specific details and show proof of denial on a separate sheet of paper and attach.

FEDERAL INCOME TAX FILING STATUS

Please attach copies of your IRS Federal and State Tax Returns for the last two years. Also, if there are any unusual expenses (such as severe medical expenses, death, etc.), please describe in detail on a separate sheet of paper and attach.

Is there any agreement specifying a contribution for this patient's medical expenses by anyone else? (Circle One) Yes No If yes how much? $____________________

Please list your dependant children:

Child (1) ____Age______________________

Child (2) ____Age______________________

Child (3) ____Age______________________

PROSTHESIS (Circle one for each of the following)

I received physical therapy instruction with my prosthesis. Yes No N/A

I received gait training instruction with my prosthesis. Yes No N/A

Are you using a prosthesis now? Yes No N/A

If no, explain why. ____

If yes, how many hours a day? ________________

How many prosthetics have you had fabricated in you lifetime? _________________

CONSUMER REQUEST FOR PROCUREMENT OF A CONSUMER REPORT

Section 604 (a) (2) of the Fair Credit Reporting Act makes provision for a consumer to request and authorize procurement of a consumer report. A consumer report may consist of 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 my application to Limbs for Life may be denied because of information contained in my consumer report and any adverse information that may be on the report could have effect, repercussions, or consequences in my efforts to obtain assistance from Limbs for Life. At my request, Limbs for Life will provide me with (1) the name, address, and a toll free telephone number of the consumer reporting agency; (2) a copy of my consumer report; and (3) a copy of my consumer rights.

I have read each of the above statements and understand what this means. As a result, and by providing the following personal information, I do hereby authorize and give permission for Limbs for Life to procure a consumer report on me.

Social Security Number: ____

Date of Birth (ex: January 15, 1977): _____________________________________

All Last Names: ____

First Name:________________________ Nickname: ______________________

Middle Name: ____

Gender (circle one): Male Female

Applicant's Street Address: _________________________________Apt #______

City/State/Zip____

Local County of Residence ____

Home Phone # _________________ Cell Phone # _______________________

*Registered State of Driver's License: ___________ DL Number: __________________
*Photocopy Attached

I certify that all of the information provided by me on this disclosure is true, correct and complete. I have not withheld any information, and I understand a consumer report may be conducted on me with my permission and authorization.

Signature: ______________________________ **Date**: __________________

AMPUTATION INFORMATION

Date of amputation: ____/____/____

Reason: ____

____

Hospital the amputation was performed: _______________________________________

City_________________ State _______Surgeon _________________________________

Physician you currently consult with: ____

Phone# (______) _____________________

If the reason for amputation was due to an injury, please give date of injury.____/____/____

Did this happen on the job? Circle one. Yes No

For any revision surgery, give date and reason ____/____/____ ____________________

____

MEDICAL HISTORY

Height _________Weight ________ With or without prosthesis?____________________

How long have you been at this weight? ________ Weight before amputation_____________

Weight Goal _______ How much does your weight fluctuate? (Try to be exact) _______

What was your general health before amputation? (Circle one)

Excellent Good Fair Poor

What is your general health now? (Circle One)

Excellent Good Fair Poor

List other conditions and or other health problems (Mental, Physical, i.e. Diabetes, Heart/ Vascular Disease) ____

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How did you find out about Limbs for Life?______________________________________