



## 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 who 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 (green 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 earn income and someone is supporting you, please have them write a letter on your behalf stating they are currently helping you out with food, shelter, etc.
  - Return required copies by email (*preferred*), fax or mail to:

**[admin@limbsforlife.org](mailto:admin@limbsforlife.org)**

**Limbs for Life Foundation**

**9606 N. May Ave., Oklahoma City, OK 73120**

**Fax 405-843-5123**

- 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](mailto:admin@limbsforlife.org).
- Our minimum waiting period is two months following receipt of your complete application and all required documents. **Other available resources should be pursued during this time.**

**\*Limbs for Life cannot guarantee funding for all applicants.**

**\*Applicants are considered on a case-by-case basis.**

### **When an applicant is approved for funding:**

- Applicant and Prosthetic Clinic will receive a call confirming approval of applicant.
- Applicant may schedule appointment(s) with the prosthetist to begin the fitting process.
- Limbs for Life's approval period will expire six months (6) from the date of approval.

**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 F Maiden Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN (required for background check) \_\_\_\_-\_\_\_\_-\_\_\_\_

Ethnicity/Race: African American Caucasian American Indian
Asian Hispanic/Latino Other \_\_\_\_\_

US Citizen? YES NO Have you received funding from LFL in the past? YES NO Year? \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Can you receive text messages at this #? YES NO

Alternate Phone \_\_\_\_\_ Email \_\_\_\_\_

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 financial assistance (including insurance co-pay), does not qualify for funding from Limbs for Life.

Are you currently employed? Yes No If yes, list your occupation: \_\_\_\_\_

If provided a prosthetic leg, will you plan to return to work or school? YES NO\*

\*If "NO" explain why (required) \_\_\_\_\_

What was your occupation prior to amputation? \_\_\_\_\_

Have you contacted your state vocational rehabilitation agency about the availability of help? YES 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 \$ \_\_\_\_\_

\*Please submit copies of your photo ID, SSI/SSDI & SNAP (Food Stamp) statements, pay stubs, or bank statements as proof of household income (incl. spouse income). If no income is received, submit a letter of support written by someone who is aware of your financial situation or is helping you financially.

Do you care of children under the age of 18? Yes No # of children in your care \_\_\_\_\_

Living arrangements: Rent Own Reside with friend/relative Long-Term Care Skilled Nursing Facility

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

Do you have a prescription for your prosthetic? Yes No

MEDICAL INFORMATION

Applicant Name: \_\_\_\_\_

Level of Limb Loss: LEFT ABOVE Knee RIGHT ABOVE Knee LEFT BELOW Knee RIGHT BELOW Knee

Do you currently wear a prosthesis? Yes No How long have you had it? \_\_\_\_\_

**Date of Limb Loss/Amputation:** (month & year)\_\_\_\_\_

**Cause of Limb Loss:**

Congenital Cancer Diabetes Gangrene Infection Injury/Trauma Vascular Disease

Other \_\_\_\_\_ Do you have diabetes? Yes No

**Describe the details of your limb loss:**\_\_\_\_\_

\_\_\_\_\_

**List any additional health issues:**\_\_\_\_\_

\_\_\_\_\_

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

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

**REQUIRED IMPACT QUESTIONS: (attach a separate/additional page if necessary)**

*Please use the spaces below to tell us more about you and how a prosthetic leg will allow you to lead a full life. Keep in mind, this is one of the best ways to tell us about yourself.*

- Personal Impact:** What specific challenges or limitations will a prosthetic leg help you overcome in your daily life? \_\_\_\_\_
- Family/Emotional/Social Impact:** In what ways will a prosthetic leg enhance your relationships with family or friends and/or affect your emotional health or social interactions? \_\_\_\_\_
- Financial Impact:** How might a prosthetic leg allow you to return to work or stay in a job? \_\_\_\_\_
- Mental Impact:** What are some hobbies or activities you would like to return to, to improve your mental health? \_\_\_\_\_

List any immediate concerns or circumstances we need to be aware of as we examine your application: \_\_\_\_\_

**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.
- **BACKGROUND CHECK:** 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.**

**Applicant Name (printed):** \_\_\_\_\_

**Applicant 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. **Note: Only your first name and state of residence will be used in any social media post or print material.**

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



PROSTHETIST INFORMATION
To be completed and signed by the prosthetist

PROSTHETIST Name: Certification Type:

Prosthetic Clinic: City:

Clinic Address: State & Zip:

Phone: Fax: Email:

PATIENT Name: Date of Birth:

Patient Height (ft+in): Patient Weight (lbs):

Level of Amputation (circle): RAK LAK RBK LBK

Date of Amputation (mo & yr): Cause:

Anticipated Level of Ambulation (circle): K0 K1 K2 K3 K4

Level of Motivation (circle): 1(low) 2 3 4 5(high)

Explain why this applicant is a good candidate for Limbs for Life funding:

FEE SCHEDULE

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

Table with 2 columns: Description of amputation level and Fee amount. Rows include 'Above Knee, Knee Disarticulation, Hip Disarticulation' for \$4,000 and 'Below Knee and Symes' for \$3,000.

- Checkmarks and text detailing funding conditions: Limbs for Life (LFL) will provide donated componentry, new textile items and replacement parts, as available, upon your request. LFL will not pay for work completed prior to issuing the confirmation letter... All work must be completed within six (6) months... LFL will not pay in combination with or supplementary to any other financial assistance or coverage - we do not assist with insurance co-pays.

ITEMS REQUIRED FOR PAYMENT

When final limb is delivered, submit: 'Private Pay' invoice, two (head-to-toe) Digital Photos and/or video of the patient wearing the prosthesis and Delivery Acknowledgement, signed by the patient.

This agreement, if approved by the LFL Board of Directors, is an agreement between the Foundation and the prosthetic clinic. No money shall ever be paid to the applicant. By signing this form, the prosthetic clinic 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 patient.

Prosthetist Signature: Date:

Return by email (preferred): admin@limbsforlife.org or by fax: 405-843-5123
Limbs for Life Foundation: 9606 N. May Avenue, Oklahoma City, OK 73120; 888-235-5462