PATIENT ELIGIBILITY APPLICATION

Abled Amputees of America is a not-for-profit public charity dedicated to providing the opportunity to all amputees to be their best self in health and wellness, including functional ambulation, through inspiration, support and education and the peace of mind to amputees needing financial support.

The availability of financial assistance is dependent on financial/fund-raising conditions of Abled Amputees of America, and the award of financial assistances to any patient is solely at Abled Amputees of America's discretion. Financial assistance, if provided, may be on a sliding scale basis, dependent in part upon the patient's income, assets, and other means or partial payments from insurance carriers.

Any patient seeking assistance benefits must cooperate in a timely manner with providing all required information and assisting in the completion of all necessary application materials. To be eligible for financial assistance, patients are responsible for the accuracy of all information provided, must fully complete this application, and must supply all additional information as required and requested. The supporting additional documentation required includes, but is not limited to the following:

- All W-2 forms from the previous year and Income Tax Records
- Pay stubs for all employed family members for the past three months
- Evidence of fixed income from Social Security, Workman's Compensations, Pensions, Disability, Child Support, Alimony and/or Unemployment Compensations
- All Checking and Savings account statements for the past three months

If the above cannot be supplied, a written explanation as to why must accompany this application.

The application form for the financial assistance requires a complete and thorough listing of family income, assets, liabilities, family size and the attachment of a number of documents. All of the answers and requested materials are required and will be used to determine eligibility for assistance.

Abled Amputees of America and its financial assistance policy are voluntary and discretionary and nothing in this explanation or its program is intended to create a right of contract of benefit.

NOTE: Failure to provide the following required information or an explanation as to why this information is not available may delay the processing of your application and could result in a denial for assistance.

Every reasonable effort will be made to process your application promptly and once your application has been reviewed you will receive a letter confirming the outcome.

PATIENT INFORMATION:

Application Date: _____

Section One: Patient information.
***If the patient is a minor, pleas list the parent or guardian as the applicant**

Name: _____

Address: _____

City: _____State: _____ZIP: _____

Home Phone Number: (_____) _____

Cell Phone Number: (_____) _____

Email: _____

Height: _____

Weight: _____

Social Security Number: _____-_____-_____

Date of Birth: _____

Marital Status: ☐Single ☐Married ☐Windowed ☐Divorced ☐Separated

Number of Dependents: ____(Please complete Family Information Section)

Date of Amputation: _____If two amputations:_____

Amputation Level and Side: (i.e., Above Knee right side, Below knee, left side, above elbow right side)

_____

_____

Reason for Amputation: Vascular/Diabetes, Auto Accident, Work Injury, Other…

If "Other", please explain here

_____

_____

_____

Health Insurance:

Do you have Health Insurance? ☐ Yes ☐ No

If yes, who is your insurance provider?

_____

Does your Health Insurance cover any portion of Physical or Occupational Therapy expenses? Yes or No Unsure

Do you have any means to make your co-pay payments? ☐ Yes ☐ No

Do you have any means to raise funds? (i.e. Family, friends…)_____

_____

_____

Prosthetic Device Information:

Do you currently have a Prosthesis? ☐ Yes ☐ No

If yes, how long have you had it? _____

Do you wear it daily? ☐ Yes ☐ No

If yes, how many hours on average a day do you wear it?

_____

_____

Do you currently have a Prosthetist you are working with or who you have met?

Yes or No, if yes please list name and contact information.
Name:_____

Contact Phone Number:_____

Do you currently have a Physical Therapist or Occupational Therapist you have worked with or met with? ☐ Yes ☐ No

If Yes, please list Name and contact information:
Name:_____

Contact Phone Number:_____

Do you currently use in assistive devices (i.e. walker, crutches, Cane)

☐ **Yes** ☐ **No**

If yes, please describe…how long and have you used this device since the amputation?

_____

_____

_____

Do you have any issues with your other limbs/extremities? Yes or No

If yes, please explain.

_____

_____

_____

Describe your typical daily activity currently.

_____

_____

_____

_____

What is your biggest daily struggles living with an amputation?

_____

_____

_____

If you were to awarded the funds for outpatient physical or occupational therapy, would obtaining transportation be an issue for you. ☐ **Yes** ☐ **No**
If yes, please explain:

_____

_____

_____

How can Abled Amputees of America be of best service to you at this time?

_____

_____

_____

_____

_____

_____

_____

EMPLOYMENT:

What is your chosen profession?

_____

_____

Have you been able to participate in your chosen profession since your amputation? ☐Yes or ☐No

Are you currently employed? If yes, please provide the following contact information.

Current Employer:

_____

Address:

_____

City: _____ State: _____ZIP: _____

Phone Number: (_____) - _____

Position/Current Job Held:

_____

_____

If you are not currently employed, how long have you been unemployed?

_____

Have you applied for unemployment or are you receiving unemployment payments? ☐Yes ☐No Please explain:

_____

_____

_____

If you do not have a monthly income, please explain how your monthly expenses are paid for. -

_____

_____

_____

_____

_____

Financial Information:

Monthly Income Sources	Applicant	Spouse	Sub-Totals
Employment Income	$	$	$
Social Security Income	$	$	$
Disability Income	$	$	$
Unemployment Income	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$

Other Income	$	$	$
		Total	

Family information:

List all family members in your household named on your most recent Federal tax return, along with dates of birth.

Name of Family Member	Date of Birth	Relationship to Patient

Estimated Monthly Living Expenses:

Household Expenses	Monthly Payments	Monthly Expenses	Monthly Payments
House/Mortgage Payment/Rent	$	Automobile Insurance	$
Property Taxes	$	Liens/Wage Garnishments	$
Homeowner's Insurance	$	**Other Expenses (explain below)**	
Utilities (electricity, gas, water)	$		$
Food	$		$
Home Phone	$		$
Cell Phone	$		$
Child Support	$		$
Child Care	$		$
Credit Cards	$		$
Health Insurance Premiums	$		$
Medical & Dental Bills	$		$
Car Payment/Other Transportation	$		$
Subtotal:	$	**Subtotal:**	$
		TOTAL	$

Use the space provided below to write any additional information and comments you believe we need to make a determination in paying for your rehabilitation:

_____

_____

_____

_____

_____

_____

_____

Signature:

I certify all information is valid and complete and hereby authorize Abled Amputees of America to verify any of the above information as deemed necessary.

Applicant Name, Please Print:

_____

Signature: _____Today's Date: _____

Photo Release:

I hereby give Abled Amputees of America (AAA) permission to use images of me (including any motion picture or still photographs made by AAA of my likeness, poses, acts and appearances or the sound records made by AAA of my voice))"Images") for any purpose in connection with promoting AAA and it's activities (the "Purposes"), which may include advertising, promotion and marketing. AAA may crop, alter or modify images of me and combine such images with other images, text, audio recordings and graphics without notifying me.

(Initial Below)

Agree:_____ Disagree:_____

NOTE: Agreement to photo release is **not** required to receive funding from Abled Amputees of America.

RELEASE OF LIABILITY

In exchange for the services provided by Abled Amputees of America organized by Abled Amputees of America, an Atlanta Georgia organization ("Abled Amputees of America"), of P.O. Box 2343, Lilburn Georgia 30048-2343 and/or use of the property, facilities, and services of Abled Amputees of America, I agree for myself and (if applicable) for the members of my family, to the following:

1. I agree to observe and obey all posted rules and warnings, and further agree to follow any oral instructions or directions given by Abled Amputees of America, or the employees, representatives or agents of Abled Amputees of America.

2. I recognize that there are certain inherent risks associated with the activities of Abled Amputees of America and I assume full responsibility for personal injury to myself and (if applicable) my family members, and further release and discharge Abled Amputees of America for injury, loss or damage arising out of my or my family's use or participation in the services offered by Abled Amputees of America, whether caused by the fault of myself, my family, Abled Amputees of America, or other third parties.

3. I agree to indemnify and defend Abled Amputees of America against all claims, causes of action, damages, judgments, costs or expenses, including attorney fees and other litigation costs, which may in any way arise from my or my family's use of or participation in the services provided by Abled Amputees of America.

4. I agree to pay for all damages to the facilities utilized during the services provided by Abled Amputees of America caused by me or my family's negligent, reckless, or willful actions.

5. Any legal or equitable claim that may arise from participation in the above shall be resolved under Georgia law.

6. I agree and acknowledge that I am under no pressure or duress to sign this agreement and that I have been given a reasonable opportunity to review it before signing. I further agree and acknowledge that I am free to have my own legal counsel review this agreement if I so desire.

7. This agreement and each of its terms are the product of an arms' length negotiation between the Parties. In the event any ambiguity is found to exist in the interpretation of this Agreement, or any of its provisions, the Parties, and

each of them, explicitly reject the application of any legal or equitable rule of interpretation which would lead to a construction either “for” or “against” a particular party based upon their status as the drafter of a specific term, language, or provision giving rise to such ambiguity.

8. The invalidity or unenforceability of any provision of this agreement, whether standing alone or as applied to a particular occurrence or circumstance, shall not affect the validity or enforceability of any other provision of this agreement or of any other applications of such provision, as the case may be, and such invalid or unenforceable provision shall be deemed not to be a part of this agreement.

9. In case of emergency, please call…. (Relationship:_____at _____Telephone Number).

I HAVE READ THIS DOCUMENT AND UNDERSTAND IT. I FURTHER UNDERSTAND THAT BY SIGING THE RELEASE, I VOLUNTARILY WAIVE CERTAIN LEGAL RIGHTS.

Name:

_____

Signature: _____ Date: _____

Return completed application to:

Abled Amputees of America
P.O. Box 2343
Lilburn Georgia 30048-2343

or scan and email to **contact@abledamputees.org**