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**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 any 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 ☐ 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 be 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 ☐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:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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**

Abled Amputees of America (“AAA”) is a non-profit organization organized under the laws of the State of Georgia whose mission is to help provide financial support to amputees needing outpatient therapy, physical therapy, and/or occupational therapy (hereinafter, “Covered Therapy”). In exchange for my participation in AAA’s programs, or receipt of AAA’s services or financial support for the Covered Therapy, or for the use of the property and facilities of AAA (hereinafter collectively referred to as “Covered Therapy Programs”), I, on behalf of myself and (if applicable) the members of my family, heirs and assigns, agree to the following:

1. I agree to observe all rules and regulations set by AAA for my participation in the Covered Therapy Programs, including any oral or written instructions or directions given by AAA, or the employees, representatives or agents of AAA.
2. I recognize that the therapy for which AAA may provide financial support as part of the Covered Therapy Programs will generally be provided by health care providers and/or therapists that are independent contractors and not employees or agents of AAA. I agree that any negligence, gross negligence, intentional wrongdoing, or other act or omission of such health care providers in the provision of Covered Therapy to me shall not be imputed to AAA under any theory of liability. I further agree to indemnify and hold harmless AAA from any such claims.
3. I recognize that there are certain inherent risks associated with participation in the Covered Therapy Programs of AAA and the actual therapy for which AAA provides financial support, including, but not limited to, personal injury, including bodily injury or death, or property damage. With this awareness, I assume full responsibility for any loss, damage or injury that may be sustained by me or my family members or to property owned by me or my family members and fully release and forever discharge, indemnify, and hold harmless AAA, its officers, employees, servants, agents, representatives, contractors, subcontractors, suppliers, or any other affiliated persons or entities (hereinafter referred to as “Releasees”), from any and all liability, claims, and demands of whatever kind or nature, either in law or in equity, which arise or may hereafter arise in any way relating to my or my family’s use or participation in the services offered by AAA, the Covered Therapy Programs, or the Covered Therapy, whether caused by the fault of myself, my family, AAA, or other third parties.
4. I agree to indemnify, defend and hold harmless the Releasees against all claims, demands, causes of action, damages, losses, liabilities, 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 AAA, the Covered Therapy Programs, or the Covered Therapy.
5. I agree to pay for all damages to the facilities utilized during the services provided by AAA caused by me or my family’s negligent, reckless, or willful actions.
6. I agree that my affiliation with AAA is completely voluntary and that I have no legal right to AAA services, the Covered Therapy Programs, or the Covered Therapy.
7. 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.
8. 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, respectively, 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.
9. This Agreement shall be binding to the fullest extent permitted by law. If any provision hereof is unenforceable or is held to be unenforceable, such provision shall be fully severable, and this Agreement and its terms shall be construed and enforced as if such unenforceable provision had never comprised a part of the Agreement. Under such circumstances, the remaining provisions of the Agreement shall remain in full force and effect, and the court construing the unenforceable provisions shall add to this Agreement and make a part hereof, in lieu of the unenforceable provision, a provision as similar in terms and effect to the unenforceable provision as may be enforceable
10. This Agreement shall be governed by the laws of the State of Georgia.
11. This Agreement shall be binding upon me, my agents, heirs, executors, administrators, successors, assigns, insurers, attorneys, representatives, and any other legal or natural persons who may claim by, through or under me.
12. In case of emergency, please call \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(relationship: \_\_\_\_\_\_\_\_\_\_\_ ) at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (telephone number).

**I REPRESENT THAT I AM LEAST 18 YEARS OF AGE, HAVE READ THIS DOCUMENT AND UNDERSTAND IT, AND AM COMPETENT TO EXECUTE THIS AGREEMENT. I FURTHER UNDERSTAND THAT BY SIGING THE RELEASE, I VOLUNTARILY WAIVE CERTAIN LEGAL RIGHTS.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Parent/Guardian’s 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**