INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

the prosthetic foundation

Prosthetic Limb Grant Application Checklist

Include a **copy** of each of the following:

- ☐ Grant Application
- ☐ Texas Driver License
- ☐ Insurance Card
- ☐ Tax Return
- ☐ Two Check Stubs
- ☐ Bank Statements – 6 Months
- ☐ Two Months' Receipts
  - ☐ Rent / Mortgage
  - ☐ Electric
  - ☐ Water
  - ☐ Phone
  - ☐ Loans
  - ☐ Medical
- ☐ Property Tax Statements
- ☐ HIPAA Release & Recommendation Letter – Primary Care Physician
- ☐ HIPAA Release & Recommendation Letter – Texas Certified Prosthetist
- ☐ Photo & Audio Release Form
- ☐ Photos

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5047 Sherri Ann Rd.
San Antonio, TX 78233
(210) 237-4400

Prosthetic Limb Grant Application

Part I – Demographics

Last Name: _____ First Name: _____ Birth Date: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Gender: ○ Male ○ Female

E-Mail: _____ U.S. Citizen/Resident? ○ Yes ○ No

Texas DL: _____ Expires: _____ SSN: _____

Marital Status: ○ Single ○ Married ○ Widowed ○ Divorced

Education Level: ○ High School ○ Undergraduate ○ Graduate

Emergency Contact: _____ Phone: _____

Part II – Medical Condition

Amputation

Left: ☐ Below Knee ☐ Above Knee ☐ Below Elbow ☐ Above Elbow

Right: ☐ Below Knee ☐ Above Knee ☐ Below Elbow ☐ Above Elbow

Date: _____ Hospital: _____ Surgeon: _____

Cause: ☐ Illness ☐ Trauma ☐ Congenital ☐ Other

Medical History: ☐ Diabetes ☐ Hypertension ☐ Tobacco ☐ High Cholesterol

Other Conditions: _____

Primary Care Physician

Facility: _____ Physician: _____

Email: _____ Phone: _____

Texas Certified Prosthetist

Facility: _____ Prosthetist: _____

Email: _____ Phone: _____

Part III – Financial Condition

Financial Request: _____

Monthly Income

Wages	1.00
Government Benefits	1.00
Other: 1	1.00
Total Income	$ 3.00

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Monthly Payments

Rent / Mortgage _____

Electric _____

Water _____

Phone _____

Loans _____

Medical _____

Total Payments $ 0.00

Insurance: _____ Policy: _____

Own foreign property or income? ◯ Yes ◯ No

Part IV – Employment

Employer: _____ Job Title: _____ Manager: _____

Address: _____ Phone: _____ Start Date: _____

Part V – Household

Spouse

Last Name: _____ First Name: _____

Birthdate: _____ Employer: _____

Dependent 1

Last Name: _____ First Name: _____

Birthdate: _____ Gender: ◯ Male ◯ Female

Dependent 2

Last Name: _____ First Name: _____

Birthdate: _____ Gender: ◯ Male ◯ Female

Part VI – Applicant Certification

I waive all liability that may arise because of treatment I may receive through services funded by a prosthesis grant funded by The Prosthetic Foundation.

I certify that information provided in this application is correct to the best of my knowledge. I understand that any false statement or misrepresentations will disqualify me from grant disbursement, and that grant funds will only be disbursed to the prosthetics facility that fabricated and delivered my prosthesis

I authorize The Prosthetic Foundation to validate the information presented here through a consumer report pursuant to Section 604(a) (2) of the Fair Credit Reporting Act or other reasonable means, as necessary.

Applicant Signature _____ Date _____

Email to operations@theprostheticfoundation.org

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HIPAA Medical Information Release

Primary Care Physician

Patient Name: _____ Birth Date: _____

Purpose: **Prosthetic Limb Grant Eligibility**

Medical Facility: _____ Phone: _____

Physician: _____ Phone: _____

Address: _____ Email: _____

I hereby authorize and request the exchange of information between The Prosthetic Foundation (the foundation) and the above-named professional/organization as follows:

- ☐ ALL
- ☐ Assessment/Notes
- ☐ Diagnosis
- ☐ Mental Evaluations
- ☐ Immunization
- ☐ Treatment
- ☐ Summaries
- ☐ Discharge

The information release is for any time range as deemed necessary by the foundation and in any format.

I understand that release of confidential information is subject to State and Federal Laws and that they govern the confidentiality of alcohol and drug dependent persons (42CFR Par 2) and prohibits the disclosure of (1) psychotherapy notes, (2) information complied in reasonable anticipation, or for the use in civil, criminal, or administration action or proceedings. I am aware of my right to receive a **Notice of Privacy Practices** from THE PROSTHETIC FOUNDATION, the foundation.

I may revoke this authorization at any time by notifying the foundation in writing, except to the extent that: a) action has been taken in reliance on this authorization; or, b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

By signing this release, I authorize the release of my medical information as depicted above between my primary care physician or facility and the foundation which may include drug and alcohol abuse, and disclosure of the results of HIV antibody blood testing and information concerning AIDS (Acquired Immune Deficiency Syndrome) information through one year from the date of my certification below.

Patient Signature _____ Date _____

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

the prosthetic foundation

HIPAA Medical Information Release

Texas Certified Prosthetist

Patient Name: _____ Birth Date: _____

Purpose: **Prosthetic Limb Grant Eligibility**

Prosthetics Facility: _____ Phone: _____

Prosthetist: _____ Phone: _____

Address: _____ Email: _____

I hereby authorize and request the exchange of information between The Prosthetic Foundation (the foundation) and the above-named professional/organization as follows:

- ☐ ALL
- ☐ Assessment/Notes
- ☐ Diagnosis
- ☐ Mental Evaluations
- ☐ Immunization
- ☐ Treatment
- ☐ Summaries
- ☐ Discharge

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Patient's Signature: _____ Date: _____

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

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Photograph & Audio Release

Photographed/Recorded Person: _____ Birth Date: _____

Relationship to The Prosthetic Foundation:

- ☐ Grant Applicant
- ☐ Prosthetist
- ☐ Applicant's Physician
- ☐ Applicant's Caregiver
- ☐ Board Member
- ☐ Employee
- ☐ Volunteer
- ☐ Donor
- ☐ Partner
- ☐ Other

The undersigned does hereby authorize The Prosthetic Foundation and designees to:

Take and reproduce photographs, motion pictures, video and/or audio tapes, slides, or other media of the above-named person in connection with the diagnosis, care and treatment, or functional capacity of the above-named facility. Use of such materials and the person's name in connection with any publication or broadcast including, but not limited to, newspapers, television, radio, books, brochures, magazines, motion pictures, social media and organization's website; And is not limited to scientific or educational purposes and may be used in such manner and in such times and in such places as The Prosthetic Foundation shall determine, without restriction on its sole discretion.

I waive all rights that I may have to any claims for payment or royalties in connection with any exhibition, publication, or broadcast of the above regardless of whether such exhibition, publication, or broadcast is philanthropically, commercially, institutionally or privately sponsored and regardless of whether a fee for admission or rental is charged.

I release The Prosthetic Foundation, employees, board members, volunteers, and consultants from any liability in connection with the use of such materials. I understand that this authorization will remain effective indefinitely unless revoked in writing. I make such authorization on my own free will or on behalf of a minor to whom I am a biological parent to or legal guardian of.

Photographed/Recorded Person's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____