610 N Main Ave
San Antonio, TX 78205
(210) 619-6828
www.TheProstheticFoundation.org

Prosthetic Limb Grant Application

For faster review, please complete ALL fields and submit ALL requested documents

Part I – DEMOGRAPHICS

Last Name: _____ First name: _____

Physical Home Address: _____ Zip Code: _____

City: _____ County: _____ Phone: _____

Email: _____ Date of Birth: _____

The following information helps to get a better understanding of the communities we serve and uncover the needs and strengths of those communities to guide planning and development.

Select Preferred Language | Select Gender | Select Ethnicity | Select Race

Select Marital Status | Select Highest Education Level Completed

ALTERNATE CONTACT INFORMATION

Name: _____ Phone: _____ Select Relationship to Applicant

Part II - MEDICAL INFO

Select Amputation Level | Select Limb Side | Select how you currently move around

Date of Amputation: _____ Select the Reason for Amputation

Hospital Name and City where amputation occurred: _____

Has the applicant been diagnosed with any of the following conditions: (Select all that apply) Do you use Tobacco product(s)

☐ Diabetes ☐ **High Blood Pressure** ☐ Vascular Disease ☐ High Cholesterol

☐ **Other Condition(s),describe:**

PRIMARY CARE PHYSICIAN

Facility Name: _____ Physician Name: _____

Address: _____ Phone: _____

City: _____ Email: _____

TEXAS-CERTIFIED PROSTHETIST

Facility Name: _____ Prosthetist Name: _____

Address: _____ Phone: _____

City: _____ Email: _____

Part III - EMPLOYMENT INFO

Select current type of Employment

Will you return to work after getting a prosthesis?

If unable to return to work, please explain why:

Part IV - FINANCIAL INFO

HEALTH INSURANCE

Insurance Provider: _____

% covered by insurance: _____

MONTHLY HOUSEHOLD INCOME

How many persons live in your household?

How many are under the age of 18?

Type of income for Applicant		Monthly Amount: _____
Select type of income for Spouse		Monthly Amount: _____
Select type of income for other HH memb		Monthly Amount: _____
Income type for Other 2		Monthly Amount: _____

MONTHLY HOUSEHOLD EXPENSES

Monthly Amount paid

- ☐ Rent/Mortgage: _____
- ☐ Electric: _____
- ☐ Water: _____
- ☐ Phone: _____
- ☐ Medical Expenses: _____

Do you own Financial Investments?

Do you own Foreign Income or Property?

Select Reason applicant needs financial assistance

I would like a prosthesis so I can:

- ☐ Return to Work
- ☐ Enjoy hobbies like Gardening, Travel, Sports, etc.
- ☐ Exercise like Walking, Running, Lifting Weights, etc.
- ☐ Perform daily activities like Cooking, Cleaning, Shopping, etc.
- ☐ Enjoy Social Activities like participating in family events, visiting with friends, etc.
- ☐ Other, describe in the box below

If granted a prosthetic, I'm willing to improve my health by:

- ☐ Managing my diabetes
- ☐ Managing my high blood pressure
- ☐ Managing my cholesterol levels
- ☐ Not smoking or using tobacco products
- ☐ I will advocate for The Prosthetic Foundation and the amputee community
- ☐ Other, describe in the box below

Part VI - APPLICANT CERTIFICATION

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

I certify that the 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 fabricates and delivers 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

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

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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 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.

I may revoke this authorization at any time by notifying The Prosthetic 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 Prosthetic 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

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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 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 Prosthetic Foundation and in any format.

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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 Prosthetic 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'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	Employee
Prosthetist	Volunteer
Applicant's Physician	Donor
Applicant's Caregiver	Partner
Board Member	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: _____

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Prosthetic Limb Grant Application
Checklist

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

Use this checklist to ensure that you are including all of the necessary documents with your completed and signed application.

- ID included?
- Insurance card included?
- Tax Returns included?
- Income documents included?
- Bank Statements included?
- Photos

Please include a copy of the bills you have reported on this application

- Bill for Rent or Mortage includ
- Electric bill included?
- Water bill included?
- Phone bill included?
- Property Tax bill included?
- Medical bills included?