INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

Prosthetic Limb Grant Application
Checklist

Include the following documents with the completed and signed application:

- Grant Application, completed and signed by applicant
- Texas Driver License or Photo ID
- Insurance Card, if any
- Tax Returns for last 2 years
- Check Stubs for last 2 months, if applicable
- Bank Statements for the last 6 months
- Receipts for the last 2 months for the following items:
  - Rent / Mortgage
  - Electric
  - Water
  - Phone
  - Medical
  - Property Tax Statements
- HIPAA Release & Letter of Support from Primary Care Physician
- HIPAA Release & Letter of Support from Texas Certified Prosthetist
- Photo & Audio Release Form
- Photos, before and after receiving a prosthetic device

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

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

Prosthetic Limb Grant Application

Part I – DEMOGRAPHICS

Last Name: ____________ First name: ____________

Address: ____________ Phone: ____________

City: ____________ County: ____________ Zip Code: ____________

Email: ____________ SSN: ____________

Date of birth: Primary language:

Form of Identification:	☐	State-issued ID	☐	Driver's License	☐	Other:	
State:		Number:				Expiration date:	
Gender:	☐	Male	☐	Female	☐	Bi-Gender	
Ethnicity:	☐	Hispanic	☐	Non-Hispanic			
Race:	☐	Latino	☐	White	☐	Black	☐ Asian
Marital Status:	☐	Single	☐	Married	☐	Divorced	☐ Widowed
Education Level:	☐	Less than High School	☐	High School Graduate	☐	Greater than High School	

EMERGENCY CONTACT Name: ____________

Relationship: ____________ Phone: ____________

Part II - MEDICAL INFO

AMPUTATION

☐ Below Knee ☐ Above Knee ☐ Left Leg ☐ Right Leg

Hospital: ____________ Surgeon: ____________

Cause for amputation: Date of Amputation: ____________

☐ Illness ☐ Trauma ☐ Congenital ☐ Other

Describe: ____________

Have you been diagnosed with any of the following conditions:

☐ Diabetes ☐ Hypertension ☐ High Cholesterol

☐ Cardiovascular Disease ☐ Peripheral Arterial Disease ☐ Use Tobacco

PRIMARY CARE PHYSICIAN

Facility: ____________ Physician Name: ____________

Address: ____________ City: ____________

Email: ____________ Phone: ____________

TEXAS-CERTIFIED PROSTHETIST

Facility: ____________ Physician Name: ____________

Address: City:

Email: ____________ Phone: ____________

Part III - EMPLOYMENT INFO

Are you currently employed? ☐ Yes ☐ No

If not, what is preventing you from working? ____________

What type of work do you do or have done before? ____________

Part IV - FINANCIAL INFO

HEALTH INSURANCE

Plan Name: ____________________ Percentage they pay: __________

MONTHLY HOUSEHOLD INCOME

SELF:	☐ Disability or Government Benefits	☐ Work or Retirement Benefits	Monthly Amount:
SPOUSE:	☐ Disability or Government Benefits	☐ Work or Retirement Benefits	Monthly Amount:
OTHER:	☐ Disability or Government Benefits	☐ Work or Retirement Benefits	Monthly Amount:
OTHER:	☐ Disability or Government Benefits	☐ Work or Retirement Benefits	Monthly Amount:

MONTHLY HOUSEHOLD EXPENSES

☐ Rent/Mortgage:	Monthly Amount YOU pay	
☐ Electric	Monthly Amount YOU pay	
☐ Water	Monthly Amount YOU pay	
☐ Phone	Monthly Amount YOU pay	
☐ Medical	Monthly Amount YOU pay	

Do you have any type of financial investments? ☐ Yes ☐ No

Do you own foreign property or income? ☐ Yes ☐ No

Part V - HOUSEHOLD INFO

How many persons live in your household? How many of these persons do you financially support?

SPOUSE

Last name: __________ **First name:** __________

Date of birth: ☐ Works or is Retired ☐ Other

DEPENDENT 1

Last name: __________ First name: __________

Date of birth: ☐ Attends school ☐ Works

DEPENDENT 2

Last name: __________ First name:

Date of birth: ☐ Attends school ☐ Works

DEPENDENT 3

Last name: __________ First name: __________

Date of birth: ☐ Attends school ☐ Works

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 __________

Email this completed application and all required documents to: **vlanderos@TheProstheticFoundation.org**

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

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	Immunization
Assessment/Notes	Treatment
Diagnosis	Summaries
Mental Evaluations	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

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	Immunization
Assessment/Notes	Treatment
Diagnosis	Summaries
Mental Evaluations	Discharge

The information release is for any time range as deemed necessary by The Prosthetic 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 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: _________________