MIRACLE LIMBS-COURAGE IN MOTION
APPLICATION

MIRACLE LIMBS-COURAGE IN MOTION
6017 Pine Ridge Rd. Suite 303
NAPLES FLORIDA 34119
239-591-8393
www.miraclelimbs.org
Robert@miraclelimbs.org

INSTRUCTIONS

Please fill out the following forms thoroughly. Feel free to have someone assist you with this application, if necessary. Please have a prosthetist of your choice review, fill out, and sign the prosthetist pages. If you do not already have a prosthetist, let us know and we can suggest a few in your local area. Once the amputee and prosthetist sections are completed, the entire packet should be mailed to Miracle Limbs-Courage in Motion

Your application will go before the Board of Directors for confirmation. If selected, we will send a letter to you and your prosthetist informing you that you have been approved for financial assistance.

* One very important detail is that Miracle Limbs-Courage in Motion does not and will not commit to paying any charges incurred before an applicant has been confirmed and notified by mail. Consequently, if an individual desires to obtain a prosthesis through Miracle Limbs-Courage in Motion they must wait for confirmation before incurring charges, such as being fitted or ordering componentry.

THE APPLICATION

All information submitted in this application is strictly confidential and will be used only for the selection process. For this application to be considered, the application must be completed in its entirety. If any information is left out, or the forms are not signed and dated, the application will not be eligible for consideration.

Please check that these things are included before sending back your application:

- ✓ You and your prosthetist have signed and dated the patient and prosthetist agreement.
- ✓ You have signed and dated the applicant’s release of claims.
- ✓ You have attached a copy of your doctors prescription.
- ✓ You have attached photos.
- ✓ You have attached copies of your IRS Federal and State Tax returns for the previous year.

Please describe your current physical and financial situation. Include details about how your amputation affects your life and how you would benefit from a prosthesis.

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GENERAL INFORMATION

Applicant Name ________________________________ Date of birth___________

SS#____

Address____

City____________________State_________________________Zip_________________

How long have you lived at the above address?____________________________

Home phone # [___]______________ Work phone # [____]______________________

Email Address: ____

Employer [company] name____

Employer Address____

City____________________State____________________Zip_____________________

How long have you been employed at this job?_____________________________

Spouse's Name____

Spouse's Employer____

Employer Address____

City____________________State______________________Zip___________________

IF MINOR

Parent's name or legal guardian____

Home address____

City_________________________State________________Zip_____________________

How long have you lived at above address?________________________________

Home phone # [____]_______________Work phone# [____]______________________

Employer____

Employer's Address____

City________________________State_____________________Zip________________

Insurance information

Insured person____

Insurance company____________________________ phone # [___]___________

Employer [if group coverage]____

Policy #_________________ID #____________________Group #______________

Additional information____

2nd Insurance company_________________________Phone # ________________

Explain why insurance company is not paying_______________________________

____

Have you applied for financial aid through other organizations? Yes no

If yes, where?____________________________were you denied? Yes no

Please write specific details and show proof of denial on a separate sheep of paper and attach.

INCOME AND EXPENSES REPORT

Please attach copies and IRS Federal and State tax returns for the last year. Also, if there are any unusual expenses [such as severe medical expenses, deaths, etc.]. Please describe in detail on separate sheet of paper and attach.

Is there any agreement specifying a contribution for this patient's medical expenses by anyone else?
Circle one Yes No If yes, how much? $______________

How many children, including the applicant, are residing in your home and/or receiving support from you?
____

Please list your dependent children:

Child [1] ____ Age ___________________________

Child [2] ____ Age ___________________________

Child [3] ____ Age ___________________________

Child [4] ____ Age ___________________________

Child [5] ____ Age ___________________________

AMPUTATION INFORMATION

Date of amputation ______/ ______/ ______

Reason: ____

____

Hospital amputation was performed: ____

City _______________________ State _______________________ Surgeon _____________________

Physician you currently consult with: ____

Phone # [______]____________________________

My level of amputation is: [circle all that apply]

Below knee   above knee   below elbow   above elbow   other

Please indicate if there is more than one extremity involved ____________________________________

If the reason for amputation was due to an injury, please give date of injury. ____/____/____

Did this happen on the job? Circle one.   Yes   No

If yes, describe how it happened: ____

____

For any revision surgery, give date and reason ____/____/____ ___________________

____

PROSTHESES

Circle one for each of the following:

I received physical therapy instruction with my prosthesis. Yes   No   N/A

I received gate training instruction with my prosthesis.   Yes   No   N/A

Are you willing to obtain instruction at this time if advised?   Yes   No   N/A

Are you willing to be an in-patient, if advised?   Yes   No   N/A

Are you using a prosthesis now?   Yes   No   N/A

If no, explain why. ____

If yes, how many hours a day? __________________

How many prostheses have you had fabricated since your amputation? _______________________

How did you learn about Miracle Limbs-Courage in Motion? _______________________________

____

Please list the activities [sports, hobbies and recreational activities] prior to amputation: __________

____

Describe the job in which you were employed prior to amputation and how long you were employed

At the job: ____

____

What things do you want to do that you cannot do at this time? Be specific.

____

____

Why are you unable to do these things? Be specific.

____

____

Check the following reasons that indicate how you will use your prosthesis:

- o Functional reasons-every day activities
- o Cosmetic-appearance only
- o Profession, which will be ____
- o Leisure, recreational activities, which will be___________________________________

  ____

- o Competitive sports, which will be ____

Are you working now? Circle one. Yes No

If Yes, what is your job title? __________________ Describe briefly what your job entails [specifically with regards to walking, lifting, climbing, carrying, sitting].________________________
____

FEDERAL INCOME TAX FILING STATUS

Check your status of last year:

- Single
- Married, filing jointly
- Married, filing separately
- Head of household

Check your status this year:

- Single
- Married, filing jointly
- Married, filing separately
- Head of household

MEDICAL HISTORY

Height ______ Weight ______ With or without prosthesis? ____________________________________

How long have you been at this weight? ____

Weight before amputation __________________ weight goal ___________________________________

How much does your weight fluctuate? [try to be exact] _______________________________________

What was your general health before amputation? Circle one.

Excellent Good Fair Poor

What is your general health now? Circle one.

Excellent Good Fair Poor

List other conditions and or other health problems [mental, physical, i.e. Diabetes, Heart/vascular disease] -
____

____

List all medications which you are currently taking ____

____

PROSTHETIST INFORMATION

In order for Miracle Limbs-Courage in Motion to fulfill its mission of providing prosthetic care to amputees in need, there must be a combined humanitarian effort from the foundation and the prosthetist. This is accomplished by Miracle Limbs-Courage in Motion reimbursing the clinic for the agreed amount for the prosthetic device and fitting between the prosthetist and the foundation.

The prosthetist will inform Miracle Limbs-Courage in Motion via email to Robert@miraclelimbs.org detailing suggested components and socket information and cost to be used on the patient.

Miracle Limbs-Courage in Motion will review patient's profile, and suggest alternatives on componetry, etc. if applicable. Upon agreement between prosthetist and Miracle Limbs-Courage in Motion, the fitting process can begin.

***Repairs and adjustments will be covered for the first 6 months after patient takes delivery of the prosthesis. The foundation will not reimburse more than is allowed on the agreed fee schedule. In accordance with the Miracle Limbs-Courage in Motion bylaws, all assistance once the patient is fitted must be approved by Miracle Limbs-Courage in Motion.**

PATIENT AND PROSTHETIST AGREEMENT

For this application to be considered, the patient and prosthetist must sign and date the form below. This agreement, if approved by the Board of Directors, is an agreement between the foundation and the clinic. No money shall ever be paid to the applicant.
Additionally, by signing this form, the prosthetist agrees to absorb the additional costs above the amount designated in the fee schedule, so as to provide this service free-of-charge for the applicant.

CURRRENT PROSTHETIST INFORMATION

Applicant Name ____

Prosthetist Name ____

Name of Facility ____

Facility Address ____

City ___________________ State _______________________ Zip _________________________________

Facility Phone # ____

Prosthetist Email ____

Certification Type _________________________________ Certification # __________________________

State License Type ____

Number of years in patient care _________________ Number of years in business _________________

The signatures below indicate the prosthetist and patient understand that the Miracle limbs-Courage in Motion Foundation will reimburse the clinic based upon the fee schedule, if the Board of Directors approves the patient's application. It is understood that any charges incurred above the amount in the fee schedule are the responsibility of the clinic, not the patient or the Miracle Limb-Courage in Motion Foundation.

Prosthetist Signature ____________________________________ Date ______________________

Patient Signature ____ Date ______________________

BEFORE & AFTER PHOTOGRAPHS

Please submit photographs of the recipient with this application <u>and</u> with the invoice after delivery of the prosthesis. These pictures may be used for media purposes. Simply email 3 – 4 digital photos to

Robert@miraclelimb.org . [Please do not send videos]. Pictures should include a full body shot in appropriate clothing where the limb is visible. Please take a picture with and without the prosthesis.

MIRACLE LIMBS-COURAGE IN MOTION
APPLICATION RELEASE OF CLAIMS

I have applied to The Miracle Limbs-Courage in Motion Foundation [" Foundation"] for financial assistance in obtaining a prosthesis and/or related services. I acknowledge that, if the Foundation awards financial assistance on my behalf, the Foundation's involvement is limited to providing financial assistance to the clinic and not to the individual. The Foundation has not made any guarantees, guaranties or assurances to me regarding the prosthesis or related services.

I do hereby and for my heirs, executors, administrators and assigns, release acquit, hold harmless, and forever discharge the Foundation and its agents, employees, directors, and officers [it being agreed that it is not necessary to specifically each and every one of them] of any and all responsibility, claims, suits, obligations, liabilities, causes of action, demands, damages, costs and expenses whatsoever, known or unknown, in law, equity or otherwise, which I now have or which may hereafter accrue on account of, result from, or in any arise out of or in connection with, the prosthesis and related services.

I acknowledge that I have read and fully understand this release and the application and that I have had any and all questions I have regarding this release answered to my satisfaction.

_____________________________ _______________________________

Applicant signature Date

_____________________________ _______________________________

Witness Parent[s]/Guardian [if applicable]

PHOTO/VIDEO/MEDIA RELEASE

I,______________________________, hereby give my consent to Miracle Limbs-Courage in

Motion to use any photographs or videos taken of me for educational and/or publication purposes.

Patient signature ______________________ Date ___________________________

CONSUMER REQUEST FOR PROCUREMENT OF A CONSUMER REPORT

Section 604[a] [2] of the fair Credit Reporting Act makes provisions for a consumer to request and authorize procurement of a consumer report. A consumer report may consist of employment records, educational verification, License verification, driving history, previous address, social security verification, and public records relative to criminal charges and criminal history.

I understand that my application to Miracle Limbs-Courage in Motion may be denied because of information contained in my consumer report and any adverse information that may be on the report could have effect, repercussions, or consequences in my efforts to obtain assistance from Miracle Limbs-Courage in Motion. At my request, Miracle Limbs-Courage in Motion will provide me with [1] the name, address, and toll free telephone number of the consumer reporting agency; [2] a copy of my consumer report; [3] a copy of my consumer rights

I have read each of the above statements and understand what it means. As a result, and by providing the following personal information, I do hereby authorize and give permission for Miracle Limbs-Courage in Motion to procure a consumer report on me.

Today's Date: ____

First Name: ____ Nickname: ___________________________________

Middle Name: ____

All Last Names: ____

Applicant's Address: ____

Social Security Number: ____

Date of Birth: ____

Driver's License: [State] ___________________________ Number: ____

- Photocopy Attached

I certify that all the information provided by me on this disclosure is true, correct and complete. I have not withheld any information, and I understand a consumer report may be conducted on me with my permission and authorization.

Signature: _________________________________ Date: ___________________________________