Julia H Jensen Scholarship Fund
1234 Main Street
Hemet, CA 92543
(800) 123-4567
admin@jhjsf.org

Patient Assistance Application Instructions

Are you eligible for assistance through the Julia H Jensen Scholarship Fund? (JHJSF)?

- We provide assistance for lower limb amputees who have no other means to pay for prosthetic care including Medicare, insurance coverage or state assistance (we do not assist with co-pays)
- You must be a U.S. citizen or a permanent resident of the U.S.to apply
- You must show proof of your financial need
- You must use a prosthetist that agrees to accept JHJSF payment as full payment for their services

How to apply

- Complete Pages 1-3 of the application and have your prosthetist complete Page 4
- With your application include copies of these items:
- A readable copy of your photo ID; if you are not a U.S. Citizen, a copy of your Permanent Residence Card is required
- Proof of monthly financial income (copies of federal aid notices – SSI/SSDI/Food stamps)
- If you do not receive federal or state aid, send copies of pay stubs, bank statements or tax return to show most recent income
- Return required copies by mail, fax or email to:

Julia H Jensen Scholarship Fund

Upon receipt of completed application and all required documents, we will:

- Call you to verify your information
- Conduct a criminal background check
- Notify you if you qualify for financial assistance

When the funds become available:

- You will receive a call to confirm that JHJSF will pay for your prosthesis and that you may now make an appointment with your prosthetist to begin the fitting process
- A confirmation letter is faxed to your prosthetic clinic

JHJSF will not pay charges incurred before the confirmation letter has been issued, including being fitted or ordering componentry.

JHJSF's commitment will expire six months (6) from the date of confirmation.

Questions? Call JHJSF 800-123-4567 Mon.-Fri., 9 am to 5 pm, Central Time
or email: admin@JHJSF.org

ADULT APPLICANT INFORMATION

(Complete blanks or circle correct response)

Last Name _____First Name _____Middle_____

Marital Status_____+ Gender: M or F Maiden Name_____

Date of Birth ____/_____ /_____ SSN (required for background check)_____

Ethnicity/Race: Black/African American White American Indian Asian Hispanic/Latino Other

Country of Birth_____If not U.S., include proof of Permanent Residency
[copy of Permanent Resident Card, Naturalization Certificate, US Passport]

Address_____

City_____ State_____ Zip_____

Phone_____ 2nd Phone_____ Email_____

Alternate Contact_____ Phone_____

It is your responsibility to stay in contact with us by mail, telephone, fax or email. Notify us immediately with any change in your contact information. If we cannot reach you, your application will be delayed.

Are you currently employed? **Yes or No** If not, do you plan to return to work? **Yes or No**

Have you contacted your state vocational rehabilitation agency about the availability of help? **Yes or No**

Monthly Income $_____ Spouse Income $_____
[include copy of SSI/SSDI/food stamps, pay stubs, bank statements or most recent income tax return]

Living arrangements: Rent Own Reside with friend or relative Long Term Care Facility Other

Are you responsible for care of children under the age of 18? **Yes or No** # of children in your care_____

Do you receive assistance from or are you covered by any of the following (circle all that apply):
Medicaid Medicare Part B Social Security Disability Social Security Food Stamps Health Insurance

How did you hear about JHJSF? Internet Social Worker Doctor/Clinic Referral
Other_____

I verify that the above information is true to the best of my knowledge, and understand that this information will be kept confidential.

Patient Signature:_____ Date:_____

MEDICAL INFORMATION

Applicant Name:_____

Do you have a prescription for your prosthetic? **Yes or No**

Circle Level of Limb Loss: **Right Above Knee** **Left Above Knee** **Right Below Knee** **Left Below Knee**

Do you currently wear a prosthesis? **Yes or No** How long have you had it?_____

Circle cause of limb loss or list other

Congential Cancer Diabities Gangrene Infection Injury/Trauma Vascular Diease

Other:_____

If Injury/Trauma, describe details/circumstances of your limb loss_____

_____

_____

Date of Amputation (month/year)_____

Circle the number that best rates your overall health with 1 = Poor and 10 = Excellent

1 2 3 4 5 6 7 8 9 10

(Poor) (Excellent)

How will a new prosthetic leg improve the quality of your life and the lives of your family members?_____

_____

_____

_____

_____

I verify that the above information is true to the best of my knowledge, and understand that this information will be kept confidential.

Patient Signature:_____ Date:_____

Julia H Jensen Scholarship Fund

APPLICANT'S CONSENT FOR BACKGROUND CHECK,

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND RELEASE OF CLAIMS

(NOTE: photo release is the only optional item)

By signing below I agree to authorize the following:

- I have applied to Julia H Jensen Scholarship Fund for financial assistance in obtaining a prosthesis and /or related services. I acknowledge that if financial assistance is awarded on my behalf, Julia H Jensen Scholarship Fund involvement is limited to providing financial assistance with payment to the clinic and not the individual. Julia H Jensen Scholarship Fund does not provide prostheses or any related services. Julia H Jensen Scholarship Fund has not made any guarantees, warranties or assurances to me regarding the prosthesis or related services.
- I hereby give my permission to Julia H Jensen Scholarship Fund to obtain information relating to my employment records, educational verification, license verifications, driving history, previous address, social security verification, and public records relative to criminal charges and criminal history. I understand that this information will be used, in part, to determine my eligibility for financial assistance to obtain prosthetic care.
- I understand that my application to Julia H Jensen Scholarship Fund may be denied because of information contained in this report and any adverse information could have effect, repercussions or consequences in my efforts to obtain assistance from Julia H Jensen Scholarship Fund.
- I authorize the holder of any medical documentation or information about me to release to Julia H Jensen Scholarship Fund any information needed to determine if I qualify for financial assistance according to the conditions of Julia H Jensen Scholarship Fund.
- I do hereby completely release, acquit, hold harmless, and forever discharge Julia H Jensen Scholarship Fund and its agents, affiliates, servants, employees, principals, successors, divisions, groups, subsidiaries, affiliates, affiliated companies, branches, shareholders, predecessor companies, successor companies, officers or directors, (it being agreed that it is not necessary to specifically name each and every one of them) of any and all responsibility, present or future claims, suits, obligations, liabilities, causes of action, demands, damages, costs and expenses of any nature 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 way arise out of or in connection with, the prosthesis and related services. This Release shall be binding upon the executors, administrators, personal representatives, heirs, successors, and assigns of the undersigned.

I acknowledge that I have read and fully understand this Release, Authorization, and Consent and that all my questions regarding same have been answered to my satisfaction.

Patient Signature:_____ **Date:**_____

PHOTO/VIDEO/MEDIA RELEASE (optional)

I give my consent to Julia H Jensen Scholarship Fund to use any photographs, video, or any other medium taken of me for educational and/or publication purposes.

Patient Signature:_____ ***Date:***_____

PROSTHETIST INFORMATION
To be completed and signed by the prosthetist

Prosthetist Name: _____Certification Type:_____

Name of Clinic:_____

Address: _____City/State/Zip_____

Phone ( )_____ Fax ( )_____ Email_____

Applicant Name:_____

Fill in blank or circle answer
Level of Amputation: **Right Above Knee** **Left Above Knee** **Right Below** **Knee Left Below Knee**

Reason for Amputation (If trauma, list details):_____

Anticipated Level of Ambulation: **K0** **K1** **K2** **K3** **K4**

Comments _____

FEE SCHEDULE

Fee includes **test and final socket, fabrication of prosthetic and adjustments as needed for the life of the socket**

Above Knee, Knee Disarticulation and Hip Disarticulation	**$3,500.00**
Below Knee and Symes	**$2,500.00**

- Julia H Jensen Scholarship Fund (JHJSF) will provide donated/used componentry, soft goods and replacement parts as available upon request
- JHJSF will not pay for work completed prior to your receipt of the confirmation letter stating approval of our financial commitment
- All work must be completed within six (6) months of the date of the confirmation letter
- JHJSF will not pay in combination with or supplement any other financial assistance or coverage
- Patient is eligible to re-apply for JHJSF financial assistance once every 36 months
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REQUIRED PRIOR TO PAYMENT

When final limb is delivered, **submit invoice with two (2) or more digital photographs** and/or video of the patient wearing the new prosthesis.

This agreement, if approved by the Board of Directors, is an agreement between the Julia H Jensen Scholarship Fund and the prosthetic clinic. No money shall ever be paid to the applicant. Additionally, by signing this form, the prosthetist agrees to absorb any additional costs above the amount designated in the fee schedule, so as to provide this service free-of-charge for the applicant.

Prothetist Signature:_____ Date:_____