



The International Foundation for the Physically Disabled

APPLICATION FOR ASSISTANCE

Applicant's name (please print): _____

INSTRUCTIONS

- Please fill out the following forms as thoroughly as possible. Once the forms are completed, mail it back to the IFPD address as shown above.
- All applications will be reviewed by the President of the IFPD, and may be submitted for review to the Board of Directors.
- Applicants will receive written confirmation informing them of the IFPD's decision.

Please note that the IFPD cannot pay for any charges incurred *before* an applicant has been approved for assistance by the IFPD. The IFPD will only pay for charges as pre-approved by the IFPD, and will be paid directly to the service provider (clinic). No money will ever be paid to the applicant (patient).

Information submitted in this application is strictly confidential and will be used only for the selection process. By signing this application, you give the IFPD permission to discuss any issues related to your application with your current health care providers, i.e. doctor, therapists, orthotist, prosthetist. Further, by signing this application, you give the IFPD permission to contact your insurance provider, should you have one, regarding your claim history and past payments made on your behalf.

Please initial every page. Application form must be signed and dated.

APPLICATION CHECKLIST

- Have you completed the general and medical information?
- Have you indicated what kind of device you need assistance for?
- Have you completed the insurance information? Tick if not applicable.
- Have you completed the amputation information? Tick if not applicable.
- Have you taken the Applicant/Clinician agreement to your current service provider and have they initialed and signed the applicable pages? Tick if not applicable.
- Have you signed the media release form? And have you included pictures and/or video?
- Have you signed the Release of Claims form?

Signed (applicant): _____

Dated: _____



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GENERAL INFORMATION:

Mr./Mrs./Ms.	First name:	Last name:
Date of birth (year/month/day):	Age at time of application:	Citizenship:
Address:		
State/Province:	Zip/Postal Code:	Country:
Phone (home):	Phone (other):	Email address:

If minor, please fill out the following information for the PARENT/REPRESENTATIVE OF THE APPLICANT:

Mr./Mrs./Ms.	First name:	Last name:
Date of birth (year/month/day):	Relationship to applicant:	Citizenship:
Address:		
State/Province:	Zip/Postal Code:	Country:
Phone (home):	Phone (other):	Email address:

EMPLOYMENT INFORMATION (Applicant, Parent, or Legal Guardian):

Employer's Name:		
Job Title:	How long have you been employed in this position?	
Employer's Address:		
State/Province:	Postal Code:	Country:

Initial: _____



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PLEASE INDICATE WHAT KIND OF ASSISTANCE YOU NEED:

<p>ORTHOTICS:</p> <p><input type="checkbox"/> Knee brace <input type="checkbox"/> AFO <input type="checkbox"/> Back Brace</p> <p><input type="checkbox"/> Neck support <input type="checkbox"/> Other</p>
<p>PROSTHETICS:</p> <p><input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT</p> <p><input type="checkbox"/> Below knee (BK) <input type="checkbox"/> Above knee (AK) <input type="checkbox"/> Below elbow(BE) <input type="checkbox"/> Above Elbow (AE)</p> <p><input type="checkbox"/> Other <input type="checkbox"/> Please indicate if there is more than one extremity involved</p> <p>Please provide additional information on Page 6.</p>
<p>DURABLE MEDICAL DEVICES:</p> <p><input type="checkbox"/> Wheelchair <input type="checkbox"/> Crutches</p> <p><input type="checkbox"/> Other</p>
<p>PLEASE INDICATE HOW THE ABOVE DEVICE WILL AFFECT/IMPROVE/CHANGE YOUR LIFE:</p>
<p>HOW DID YOU FIND OUT ABOUT THE INTERNATIONAL FOUNDATION FOR THE PHYSICALLY DISABLED?</p>

Initial: _____



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MEDICAL HISTORY (ALL APPLICANTS):

HEIGHT:	WEIGHT:	IS THIS WEIGHT WITH YOUR PROSTHESIS? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Not applicable
HOW LONG HAVE YOU BEEN AT THIS WEIGHT?		WEIGHT BEFORE AMPUTATION:
INDICATE YOUR GENERAL HEALTH BEFORE YOUR AMPUTATION/ACCIDENT/INJURY: <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> EXCELLENT		
INDICATE YOUR ACTIVITY LEVEL BEFORE YOUR AMPUTATION/ACCIDENT/INJURY: <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> EXCELLENT		
INDICATE YOUR GENERAL HEALTH NOW : <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> EXCELLENT		
INDICATE ANY OTHER CONDITIONS OR HEALTH PROBLEMS: <input type="checkbox"/> DIABETES <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> KIDNEY DISEASE <input type="checkbox"/> LIVER DISEASE <input type="checkbox"/> PERIPHERAL NEUROPATHY <input type="checkbox"/> VASCULAR DISEASE <input type="checkbox"/> CANCER <input type="checkbox"/> OTHER: _____ _____ _____		

Initial: _____



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INSURANCE INFORMATION (IF APPLICABLE):

INSURED PERSON:		
INSURANCE COMPANY:		PHONE NUMBER:
EMPLOYER (IF GROUP COVERAGE):		
POLICY #	ID #	GROUP #
DO YOU HAVE ADDITIONAL HEALTH INSURANCE? IF YES, PROVIDE CONTACT INFORMATION AND POLICY NUMBERS:		
EXPLAIN WHY YOUR INSURANCE COMPANY IS NOT PAYING FOR THE DEVICE YOU NEED, AND ATTACH PROOF OF DENIAL:		
HAVE YOU APPLIED FOR FINANCIAL AID THROUGH OTHER ORGANIZATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHERE? _____		
WERE YOU DENIED? _____ IF YES, PLEASE ATTACH PROOF OF DENIAL.		

Initial: _____



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AMPUTATION INFORMATION (If applicable):

Date of Amputation:		
Reason:		
If amputation was due to an accident or injury, provide the date it happened:		
Hospital the amputation was performed:		
City:	Province/State:	Country:
Surgeon:		
For any revision surgery, give date and reason: (year/month/day) _____/_____/_____		
Your current physician :		
Phone number of your physician:		
Have you received physical and/or occupational therapy with your prosthesis?		
Have you received Gait Training instruction with your prosthesis?		
Are you using a prosthesis now? <input type="checkbox"/> YES <input type="checkbox"/> NO		
If no, explain why: _____ _____		
If yes, how many hours a day? _____		
How many prostheses have you had in your lifetime? _____		

Initial: _____



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ORTHOTIST/PROSTHETIST INFORMATION (If applicable):

In order for the IFPD to fulfill its mission of providing orthotic and prosthetic care to those in need, each application we receive is considered based on the applicant's location and current health care available to the applicant.

There needs to be a combined humanitarian effort from the IFPD and current health care providers. This is accomplished by the IFPD reimbursing the clinic only for the pre-determined agreed amount between the IFPD and the clinician involved. Other costs are covered by the clinic donating their labor and time, and donated components we receive for the services to be provided.

All applicants will be assessed on a case by case basis. The IFPD and the clinician will agree on a fee, before the applicant is approved and any services provided. The IFPD will not pay for any services provided prior to approval from the IFPD.

The IFPD requires a full evaluation by the clinician justifying the type of device applied for by the applicant.

Upon receiving approval confirmation for the applicant, the clinician may request components by contacting the IFPD at theifpd@yahoo.com. All requests will be filled based on available inventory.

These are the guidelines set by the IFPD Board of Directors, in order for us to provide assistance to as many people as possible.

The IFPD Board of Directors requires strict quality control and will request feedback from all applicants.

Please complete the APPLICANT/CLINICIAN AGREEMENT form on page 8.

Initial (Applicant): _____

Initial (Clinician): _____



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APPLICANT/CLINICIAN AGREEMENT (If applicable):

Both the applicant and the clinician must sign and date this page. Your application will not be considered without this, if applicable. This agreement is between the IFPD and the clinic providing services. By signing this form, the clinician agrees to absorb any additional costs over and above the amount as approved by the IFPD. Our goal is to provide the service free-of-charge for the applicant.

CURRENT CLINICIAN INFORMATION:

APPLICANT NAME:		
CLINICIAN NAME:		
NAME OF FACILITY:		
FACILITY ADDRESS:		
CITY:	STATE/PROVINCE:	ZIP/POSTAL CODE:
COUNTRY:	FACILITY PHONE #:	FACILITY FAX #:
CLINICIAN EMAIL ADDRESS:		
CERTIFICATION TYPE:		CERTIFICATION #:
NUMBER OF YEARS IN PATIENT CARE:		

By signing this form, the clinician and patient understand that the IFPD will only pay the amount as approved by the IFPD in writing. It is further understood that any charges over and above the set amount as agreed upon between the IFPD and the clinician, are the responsibility of the CLINIC, not the patient or the IFPD. The IFPD is not responsible for any charges incurred prior to an applicant's approval.

Clinician Signature _____ Date: _____

Applicant Signature _____ Date: _____



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PHOTOGRAPHS:

Please provide, where possible, the IFPD with photographs and/or video material to assist us in determining your eligibility for assistance.

Pictures should include a full body shot in appropriate clothing with the limb visible – with and without a prosthesis, if applicable.

Pictures and/or video may be used for media and/or fundraising purposes.

I, _____, hereby give my consent to the *International Foundation for the Physically Disabled* to use any photographs, video or other media material taken of me for educational and/or publication purposes.

Patient/Representative Signature: _____

Date: _____



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APPLICANT'S RELEASE OF CLAIMS:

I, _____, have applied to the *International Foundation for the Physically Disabled* (IFPD) for financial assistance in obtaining a prosthetic, orthotic or durable medical device.

I acknowledge that, if the IFPD awards financial assistance on my behalf, the IFPD's involvement is limited to providing financial assistance to the clinic, and not the individual. The IFPD cannot make any guarantees, warranties or assurances to me regarding the product or related services provided.

I, the undersigned, hereby release and forever discharge the *International Foundation for the Physically Disabled* (IFPD) and its agents, administrators, officers, employees and directors 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 I may hereafter accrue on account of, resulting from, or in any way arise out of my connection with, the device I receive from the *International Foundation for the Physically Disabled* (IFPD), and any related services.

The undersigned hereby declares that the terms of this agreement have been completely read and are fully understood and voluntarily accepted for the purpose of receiving a prosthetic, orthotic or DME device from the *International Foundation for the Physically Disabled* (IFPD).

Applicant signature: _____ **Date:** _____

Parent/Legal Guardian/Representative Signature: _____

Date: _____

Witnessed by (Full name): _____

Witness signature: _____ **Date:** _____