rsdsa
SUPPORTING THE CRPS COMMUNITY

Jenkins Patients Assistance Fund

Date: _____

Name: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Email Address: _____

Application must be filled out in its entirety to be considered. We are not responsible for lost applications due to the mail delivery. Please allow sufficient time to be processed.

* **RSDSA has a life-time limit of $500 aid for any applicant. However in rare circumstances, the committee may exceed this limit. All funds will be sent directly to a pharmacy, physician or other medical provider's office, a landlord, a utility, etc. We cannot provide a grant to subsidize your overall living expenses.**
  - Do you currently have RSD/CRPS? ☐ Yes ☐ No
  - Do you currently have a doctor that is treating your RSD/CRPS ☐ Yes ☐ No
    * **Please have your physician certify that you've been diagnosed with CRPS/RSD and return the certification to RSDSA on the physician's letterhead with the completed application.**
  - Are you currently employed and does your employer provide health insurance ☐ Yes ☐ No
  - Are you currently living on your own or with a caregiver? ☐ On my own ☐ With a caregiver
  - If you are living with a caregiver are they? ☐ Family Member ☐ Friend ☐ Paid Position

    If this is a paid position who is paying for it? _____
  - Are you applying for or currently receiving any of the following:

	Applying for	Received	Amount
SSI	☐	☐	
SSDI	☐	☐	
	Yes	**No**	**When**
If denied, have you reapplied?	☐	☐	
Please attach a letter from the Social Security Administration stating that you have applied or have been awarded benefits. (a copy is acceptable)			
	Applying for	**Received**	**Amount**
Food Stamps	☐	☐	
Housing Assistance	☐	☐	
Grant for training or college	☐	☐	
Medicare	☐	☐	
Medicaid	☐	☐	
Workers' Comp	☐	☐	
Other: such as faith community/Service club	☐	☐	

  - What is the total net monthly income for your family? _____
  - What are your total monthly medical expenses? _____
  - Please include your latest IRS 1040 or 1040E2 (first page only)

- So you attend support groups and/or educate yourself on your RSD/CRPS? ☐ Yes ☐ No
  If yes, what groups do you attend or visit on-line?

  _____

- Why do you feel you should receive assistance from the Brad Jenkins Patient Assistance Fund?

  _____

- How did you find out about the Brad Jenkins Patient Assistance Fund?

  _____

Previously, the Brad Jenkins Patient Assistance Fund has funded the following requests:

- Patient co-pay for treatment at community health clinic
- Paid Pharmacy Co-pay for pain medicine refill when insurance denied payment
- Purchased motor scooter for person with CRPS and cancer who was unable to walk long distances
- Paid for travel costs to visit out-of-state pain specialist
- Paid for lodging for patient to consult with out-of-state pain specialist
- Paid for 4 phone consultations with pain psychologist for a person with CRPS when Workers Compensation refused to pay for counseling.
- Paid for MRI to rule out another condition in order to help make the diagnosis of CRPS
- Paid emergency propane fill-up while recipient waits for approval from LEAP Program
- Paid for utility shut-off notices

REQUEST FOR FINANCIAL ASSISTANCE APPLICATION

Please list additional circumstances that you would like us to consider in determining your eligibility.

For additional information about the Brad Jenkins Patient Assistance Fund call: 877.662.7737