

Date: _____
 Name: _____
 Address: _____
 City/State/Zip: _____
 Phone Number: _____
 Email Address: _____

Application must be filled out in its entirety and be legible to be considered. Please allow sufficient time to be processed.

- **Each application is reviewed by RSDSA's Jenkins committee. It is a one-time award. We cannot provide a grant to subsidize your overall living expenses. We will not pay for expenses already incurred for medical care.**
 - Do you currently have CRPS/RSD? Yes No – Please provide medical documentation that you have CRPS (must be within the one year of the date of this application).

1. Do you currently have a doctor that is treating your CRPS/RSD? Yes No
2. Are you currently employed? Yes No
3. Does your employer provide health insurance? Yes No
4. Are you currently living on your own or with a caregiver? On my own With a caregiver
5. 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? _____

6. Are you applying for or currently receiving any of the following:

	Applying for	Received	Amount
SSI	<input type="checkbox"/>	<input type="checkbox"/>	
SSDI	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes	No	When
If denied, have you reapplied?	<input type="checkbox"/>	<input type="checkbox"/>	
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
SNAP	<input type="checkbox"/>	<input type="checkbox"/>	
Housing Assistance	<input type="checkbox"/>	<input type="checkbox"/>	
Grant for training or college	<input type="checkbox"/>	<input type="checkbox"/>	
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	
Workers' Comp	<input type="checkbox"/>	<input type="checkbox"/>	
Other: such as faith community/Service club	<input type="checkbox"/>	<input type="checkbox"/>	

7. What is the total net monthly income for your **household**? _____
8. What are your total monthly medical expenses? _____
9. Please include your latest IRS 1040 or 1040EZ (first page only)

10. 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?
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11. Why do you feel you should receive assistance from the Brad Jenkins Patient Assistance Fund?
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12. How did you find out about the Brad Jenkins Patient Assistance Fund?
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13. If you're applying for assistance to pay a heating or electricity bill, please document that you have approached the utility to set-up a payment plan or for shut-off protection. Have you applied for a Low Income Energy Assistance Program (LIHEAP) grant? If you are applying for help in paying your rent, please explain how you will pay it in the future.
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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. Please attach a typed statement if more space is needed to answer any of the questions.

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