rsdsa
SUPPORTING THE CRPS COMMUNITY

Jenkins Patient Assistance Fund

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. The grant is for emergency financial expenses only. It is a one-time award of $500. 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 – If you answered yes, 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	☐	☐	
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**
SNAP	☐	☐	
Housing Assistance	☐	☐	
Grant for training or college	☐	☐	
Medicare	☐	☐	
Medicaid	☐	☐	
Workers' Comp	☐	☐	
Other: such as faith community/Service club	☐	☐	

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)

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10. Do 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?

_____

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

_____

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

_____

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.

_____

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.