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 up to $1000. We may cover the costs of medications, travel to see medical professionals, utilities, food and other costs. 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
- Paid for car insurance to allow travel to medical appointments

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.