

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	<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. 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?

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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.

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.