rsdsa
SUPPORTING THE CRPS COMMUNITY

TJ and Mary Jo Whalen Patient Assistance Fund

Date: _____

Name: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Email Address: _____

- **Applications will be reviewed by RSDSA's Assistance Program committee case by case. The grant is for non-emergency financial expenses only. It is a one-time award. This grant is to offer assistance with accessibility support, assistance programs, medical, and other non emergency assistance to the CRPS community.**

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

- 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)

rsdsa
SUPPORTING THE CRPS COMMUNITY

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. **How did you find out about the TJ and Mary Jo Whalen Patient Assistance Fund?**

_____

12. **Why do you feel you should receive assistance from the TJ Whalen Assistance Fund?**

_____

_____

_____

_____

_____

13. **What are you requesting assistance for? Please summarize your request including costs.**
If you're applying for assistance to pay for accessibility improvements to your home or for other assistance please provide quotes or other relative information for the amount you are requesting. Previous expenses will not be considered.

_____

_____

_____

_____

_____

REQUEST FOR 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. Please send completed application to: slkweiner@rsds.org or mail to RSDSA 99 Cherry Street MIlford, CT 06460