TJ & Mary Jo Whalen Patient Assistance Fund

Date: _____

Name: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Email Address: _____

- **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 for it to be processed.

1. 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).**
2. Do you currently have a doctor that is treating your CRPS/RSD? ☐ Yes ☐ No
3. Are you currently employed? ☐ Yes ☐ No
4. If employed, does your employer provide health insurance? ☐ Yes ☐ No
5. Are you covered by other health insurance? Medicare ☐ Medicaid ☐ Other ☐
6. Are you currently living on your own or with a caregiver? ☐ On my own ☐ With a caregiver
7. Do you get assistance from another source (SNAP, Workman's Comp, Pension, etc.)? Yes ☐ No ☐
8. 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: State/Faith/Community (Please attach list)	☐	☐	

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

12. If you have a diagnosis by a physician, it can be found in your medical records. **We do not need all of your medical records, just the page that indicates your diagnosis.**

13. What are you asking for, and what is the reason for your request? (Please be specific)

13. Please list the **dollar costs** that you are requesting (i.e., Rent, Bills, Treatments, Wheelchair, etc.) and **include documentation to support your request.**

Please Note: All payments are made directly to providers and vendors.

Applications will be reviewed by RSDSA's Assistance Program committee, case by case.

Important: If your application is not complete, RSDSA won't be able to put it through the approval process.

Use the Checklist is below to be sure you have included all documentation:

- ☐ **What you are specifically asking for.**
- ☐ **Dollar Amount of your request including invoices as proof of documentation**
- ☐ **A copy of your most recent diagnosis from your Medical Provider (received within the last year)**

Financials:

- ☐ **Social Security income**
- ☐ **Taxes**
- ☐ **Proof of income**
- ☐ **Total Net Income for your household**
- ☐ **Total monthly medical expenses**
- ☐ **Any Assistance that you are receiving (Housing, SNAP, Medicaid, Workman's Comp, etc.)**

How did you find out about our programs? ☐ **RSDSA website** ☐ **Word of Mouth** ☐ **Brochure** ☐ **Social Media**