Patient Assistance Application Instructions (21 or under only)

- Review Frequently Asked Questions to assure that you are eligible for assistance
- Fill out all forms completely, including required signatures. If something does not apply to you, indicate N/A
- **Incomplete Applications Will Delay the Approval Process**

When completed:

- Mail, email or fax application and copy of readable identification - Florida Driver's License or Florida Identification Card to:

Rise Up Foundation
8785 SW 165 Ave Suite 109
Miami FL 33193
Fax 866-583-0245
info@riseup.foundation

Upon receipt of completed application, Rise Up Foundation will:

- Review information
- Conduct a criminal background check
- Notify patients if they qualify for financial assistance

When the funds become available:

- Patient will receive a call to confirm that prosthetic work may begin at this time
- Confirmation letter mailed to Advance Motion Control and patient

Rise Up Foundation will not make any payments before the confirmation letter has been issued

FREQUENTLY ASKED QUESTIONS

1. Am I eligible for assistance through Rise Up Foundation?

- Rise Up Foundation provides assistance for amputees with Lower Limb Loss. If funds are available, upper limb loss will be considered
- Applicant must be a resident of Miami-Dade County
- Applicant must be a U.S. citizen or a permanent resident of the U.S.
- Applicant must have no other means to pay for prosthetic care including Medicare, insurance coverage or state assistance
- Applicant must work with Advance Motion Control. Payments will only be approved and payable to Advance Motion Control

2. How do I apply for assistance?

- Complete the application and include a readable copy of your photo ID (If not a US citizen, you must send a copy of your Permanent Resident Card
- Send application and photo ID to Rise Up Foundation by mail, email or fax

3. How long will it take to get my new Prosthetic?

- Once your complete application is received, process can take up to four weeks
- Once approved, you will be included in the Waiting List until funds are available. This may take as long as six (6) months

4. What if I gain other coverage for my prosthetic care prior to receiving confirmation from Rise Up Foundation?

- Notify us as soon as possible so that the funds can be used to help another amputee

5. Further Questions:

- Call our office between 9:00 a.m. and 5:00 p.m., at 305-432-2257 or email info@riseup.foundation to answer your questions!

APPLICANT INFORMATION for person under 18 years of age

Last Name: ______________________ First Name: ______________________ Middle: ____________

Date of Birth: ________/______/________ SSN: ___________________________ Gender: M___ F___

Ethnicity: African American ___Asian ___Caucasian___ Hispanic___Multiracial____Native American ____Other___

U.S. Citizen?_____ or Permanent Resident of the U.S.?_______ [*Provide copy of Permanent Resident Card*]

Mailing Address: ____

City: _________________________________ State: _____________ Zip: ____________________

Parent or Legal Guardian Information

Parent or Legal Guardian Name ____
(Circle One)

Permanent Mailing Address: ____

City: _________________________________ State: _____________ Zip: ____________________

Home Phone : __________________ Cell: __________________ Work : ____________________

Email Address: ____

Who may we call if you are unavailable? _________________________ Phone: _________________

Occupation: ____________________________ Employer: ___________________________________

Monthly Employment Income:$ _________________________ Other Income:$ _________________

Do you receive assistance from or are you covered under any of the following (circle all that apply):

Medicare Social Security Disability Social Security Food Stamps

Health Insurance (group or individual) Provide Name and Policy # ______________________________

Community, State and/or Federal Assistance (describe): ______________________________________

____

If you have applied for any of the above or any other financial assistance, describe type and status of application: ____

If you receive disability assistance of any kind, describe your qualifying disability: _________________

____

Is any other person or entity legally responsible for patient's medical bills (e.g. Title XIX, local government assistance programs, guardian, other insurance programs, etc.)? If YES, list: ___________________

____

I verify that the above information is true to the best of my knowledge, and understand that this information will be kept strictly confidential.

Parent/Guardian Signature: ____ Date: _____________

Clinic Signature: ____ Date: __________________

MEDICAL INFORMATION

Applicant Name: ____

Current Prosthetist/Clinic ____

Name and phone number of Current Physician: ______________________________

Circle Level/Location of Lower Limb Loss:

Above Knee Right   Above Knee Left   Below Knee Right   Below Knee Left

Is limb loss congenital? Yes_____   If not congenital, complete the box below:

Date of Amputation:________________________Cause for limb loss (circle all that apply)

Vascular   Diabetes   Blockage   Infection   Cancer   Frost Bite   Circulatory   Injury/Trauma   Other

If trauma or injury, describe details, cause(s) and circumstances surrounding amputation/loss of limb: ____

____

____

____

Name of hospital, city, state where amputation was performed: ____________________

____

*Other conditions or health problems (Check all that apply)

Cancer __________________	Diabetes _____________________	Epilepsy ______________
Heart Disease ____________	High Blood Pressure ___________	Stroke ________________
Anemia __________________	Kidney Disease _______________	Glaucoma _____________
Allergies _________________	Asthma _____________________	Mental Illness ___________
Arthritis __________________	Tuberculosis __________________	Alzheimer's _____________

Other
(Describe)___________________________________

How did you hear about Rise Up Foundation? ______________________________

Doctor/Clinic Referral______ Internet_____Social Worker ______ Other ______________________

I verify that the above information is true to the best of my knowledge, and understand that this information will be kept strictly confidential.

Parent/Guardian Signature: ______________________________Date:______________

RISE UP FOUNDATION

PARENT OR GUARDIAN'S CONSENT FOR BACKGROUND CHECK,

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND RELEASE OF CLAIMS,

Initial each item that you agree to authorize (NOTE: *The photo release is the only optional item*):

_____ I have applied to Rise Up Foundation for financial assistance in obtaining a prosthesis and /or related services. I acknowledge that if financial assistance is awarded on my behalf, Rise Up Foundation's involvement is limited to providing financial assistance with payment to Advance Motion Control the clinic and not the individual. Rise Up Foundation does not provide prostheses or any related services. Rise Up Foundation has not made any guarantees, warranties or assurances to me regarding the prosthesis or related services.

_____ I hereby give my permission to Rise Up Foundation to obtain information relating to my employment records, educational verification, license verifications, driving history, previous address, social security verification, and public records relative to criminal charges and criminal history. I understand that this information will be used, in part, to determine my eligibility for financial assistance to obtain prosthetic care.

_____ I understand that my application to Rise Up may be denied because of information contained in this report and any adverse information could have effect, repercussions or consequences in my efforts to obtain assistance from Rise Up.

_____ I authorize the holder of any medical documentation or information about me to release to Rise Up Foundation any information needed to determine if I qualify for financial assistance according to the conditions of Rise Up Foundation.

PHOTO/VIDEO/MEDIA RELEASE

_____ I give my consent to Rise Up to use any photographs, video, or any other medium taken of me for educational and/or publication purposes.

_____ I do hereby completely release, acquit, hold harmless, and forever discharge Rise Up Foundation and its agents, affiliates, servants, employees, principals, successors, divisions, groups, subsidiaries, affiliates, affiliated companies, branches, shareholders, predecessor companies, successor companies, officers or directors, (it being agreed that it is not necessary to specifically name each and every one of them) of any and all responsibility, present or future claims, suits, obligations, liabilities, causes of action, demands, damages, costs and expenses of any nature whatsoever, known or unknown, in law, equity or otherwise, which I now have or which may hereafter accrue on account of, result from, or in any way arise out of or in connection with, the prosthesis and related services. This Release shall be binding upon the executors, administrators, personal representatives, heirs, successors, and assigns of the undersigned.

I acknowledge that I have read and fully understand this Release, Authorization, and Consent and that I have had any and all questions I have regarding same answered to my satisfaction.

Parent/Guardian Signature: ____ Date: ________________