Date received in office: _____

The Joyce & Arthur Siegfried Memorial Fund

Application for Purchase of New Bracing or Custom-Made/Modified Shoes

2 0 2 1

DATE: _____

1) **Name:** _____

Address: _____

City: _____ **State:** ____ **ZIP/Postal Code:** _____ **Country:** _____

Birthdate: _____ **E-mail:** _____

Phone: _____ **Fax:** _____

Please indicate best time for telephone interview. _____

2) Are you a member of PHI? ❑ Yes ❑ No

If not, how did you hear about this opportunity for funds? _____

_____

3) What year did you initially contract polio? _____

4) How will this purchase of bracing or shoes impact your ability to live independently? (Add another sheet if needed, but limit your response to 750 words.)

_____

_____

_____

_____

5) Was the purchase recommended/prescribed by a health professional? ❑ Yes ❑ No

6) What type/brand of new bracing or custom-made/modified shoes will assist you in living independently? _____

7) Please supply information about the company who has agreed to supply your braces/shoes.

Name: _____

Address: _____

City: _____ State: _____ ZIP/Postal Code: _____ Country: _____

Phone: _____ Hours: _____

Name of orthotist/pedorthist and phone (if different from above): _____

_____

8) Do you have medical insurance? ❑ Yes ❑ No *(If no, skip to #9)*

Please note checking **NO** *indicates that you have no medical insurance available to you at all.*

Do you have Medicare? ❑ Yes ❑ No

As applicable, please state **secondary** insurance company name:

_____

As applicable, please state any other medical coverage such as state, county:

_____

9) **Financial Worksheet** (Please attach a copy of the bill/invoice/estimate from the company.)

Total cost of Purchase	Round cost up to nearest dollar.	$ .00
Insurance payment (Primary)	*Amount to be subtracted.*	*($ .00)*
Insurance payment (Secondary)	*Amount to be subtracted.*	*($ .00)*
Additional funding	*Amount to be subtracted.*	*($ .00)*
Total amount unpaid	Total should reflect cost after all payments are deducted.	$ .00
Total amount requested	Not to exceed $800.00	$ .00

Send your application along with any supporting documentation to:
Post-Polio Health International, 50 Crestwood Executive Ctr #440, Saint Louis, MO 63126-1916.

All materials submitted to **Post-Polio Health International** become property of Post-Polio Health International and will not be returned to you; please copy any documents you submit for your own records. Application must be approved prior to purchase of shoes or braces. Thank you.