

# The L.E.A.H. (Lending Every Amputee Hope) Fund

## COMMUNITY FOUNDATION OF THE OZARKS

### APPLICATION FOR A GIFT OF HOPE

Application for assistance is based on current or on-going need of amputation. Applications for assistance will be individually evaluated by a committee after completion of this form and verification from your health care provider of medical condition. Preference is given to but not limited to those residing in Southwest Missouri. Maximum amount available is \$150 per year/per person to be used towards but not limited to medical/DME supplies or items from prosthetic companies to improve the quality of life for individuals with challenges associated with limb amputation. Information provided in this application is strictly confidential and will be used only for the purpose of grantmaking by the Community Foundation of the Ozarks.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Home Address: \_\_\_\_\_ County: \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ Email: \_\_\_\_\_

Patient/Parent/Guardian Phone: \_\_\_\_\_ Other Phone (if applicable): \_\_\_\_\_

Patient/Parent/Guardian Employer (if applicable): \_\_\_\_\_

Patient Medical Diagnosis: \_\_\_\_\_

Date of amputation: \_\_\_\_\_ Amputation location on body: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

*The LEAH Fund committee will contact your physician to confirm your amputation diagnosis.*

**Amount Requested (\$150 maximum):** \_\_\_\_\_

Please state the intended use for the funds requested (equipment, medical supplies, camp fees, items from prosthetic company-please be specific):

\_\_\_\_\_  
\_\_\_\_\_

Other agencies from which you are currently receiving funds: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Other services currently being provided: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Health Coverage: \_\_\_No \_\_\_Yes If yes, Circle type: Personal Policy Through Employer Medicaid

**CFO pays to invoice only. Cash is not provided.**

**The Leah Fund Application**

By signing this form you are agreeing that the Community Foundation of the Ozarks can receive information verifying your amputation status. I hereby certify that myself or child is an amputee and this will assist in capital equipment or other needs directly related to the amputation. I also certify that the above information is true and correct. All information is confidential and will be used only for eligibility determination.

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**Date**

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**Applicant/ Parent / Guardian****Return applications via mail or scan/email to:**

Kirsten Binder  
Community Foundation of the Ozarks  
P.O. Box 8960  
Springfield, MO 65801  
[kbinder@cfozarks.org](mailto:kbinder@cfozarks.org)

Questions? Contact: 417-864-6199