Lymphedema Foundation of South Florida

Application Directions and Checklist
Please Read Carefully

Please be sure to provide all the information requested here. An incomplete application will delay our ability to provide you with assistance. Please call us at (305)740-7292 if you have questions or would like help completing the application.

Lymphedema Foundation Of South Florida

FOLLOW STEPS 1 – 4 TO COMPLETE THE APPLICATION

Step 1: Fill out the LFSF Application completely and accurately

Step 2: Submit a copy of your most recent tax return

Step 3: Submit medical prescription for Physical Therapy/Lymphedema Therapy

Step 4: Read and check the boxes to verify the following information:

__ I am currently a breast cancer patient with lymphedema either recovering from a mastectomy/lumpectomy or other related surgery.

__ I am a cancer patient with lymphedema.

__ I am a lymphedema patient with no history of cancer.

__ I have signed the bottom of page 4 of the application which serves as a medical release, giving the LFSF permission to obtain the necessary medical information to process my application.

__ I understand that the LFSF will ask personal questions about my treatment and financial status. I agree to provide accurate answers on the application and in an interview.

Lymphedema Foundation Of South Florida
7600 SW 57th Avenue, Ste 300
Miami, Fl. 33143
PH: 305-740-7292 Fax: 305-328-6624

Lymphedema Foundation of South Florida

We provide Lymphedema treatments for the uninsured
and/or underinsured patients of Dade/Broward county

Personal Information

Patient's Name _____ Male ☐ Female ☐

Date of Birth _____Social Security Number _____

Permanent Address_____

City _____ State _____ Zip _____

E-mail_____

Best number to reach you? Home_____ Work_____ Cell_____ Best time to call ____

Is there a contact person that we may discuss your application with, if we can't reach you? If so, please provide a name, phone number and relationship: _____

_____

How did you hear about the Lymphedema Foundation of South Florida? _____

Marital status: Single ☐ Married ☐

No. of dependents: _____ No. of wage earners in home: _____ Total No. in household:_____

Language(s) spoken: English ☐ Spanish ☐ Other Language(s)_____

Health insurance: None ☐ Medicaid ☐ (please submit copy of Medicaid card)

Medicare ☐ Private ☐ Other _____

Health Insurance Provider: _____ Monthly premium _____

Insurance provided through: My employment ☐ Spouse's employment ☐ Other _____

Employment status ***before*** your breast cancer diagnosis:

Full-time ☐ Part-time ☐ On leave ☐ Self-employed ☐ Retired ☐ Unemployed ☐

Employment status ***after*** your breast cancer diagnosis:

Full-time ☐ Part-time ☐ On leave ☐ Self-employed ☐ Retired ☐ Unemployed ☐

When did you last work (month/year):_____

Name: _____

Lymphedema Foundation of South Florida

Financial Information

Please enter current income (in whole dollars) from all household sources in the blanks below:

	Monthly Income
Take home wages	$_____
Employer's name, address & phone number: _____ _____ _____ _____ _____	
Spouse or partner's take home wages	$_____
Employer's name, address and phone number: _____ _____ _____ _____ _____	
TOTAL CURRENT MONTHLY INCOME:	**$_____**

Name: _____

Lymphedema Foundation of South Florida

Medical Information

Current Diagnosis

Date Diagnosed: _____ Stage: _____ Type (if known):_____

I. ☐ Primary Lymphedema

II. ☐ Secondary Lymphedema:

☐ Breast Cancer Date: _____

☐ Lumpectomy Date: _____

☐ Mastectomy Date: _____

☐ Sentinel Node Biopsy Date: _____

☐ Axillary Dissection Date: _____

No. of lymph nodes dissected _____

☐ Ovarian Cancer Date: _____

☐ Prostate Cancer Date: _____

Chemotherapy: Start Date: _____ End Date: _____

Radiation: Start Date: _____ End Date: _____

PLACE OF TREATMENT: _____

Please fill out the contact information below:

	Name:	Location:	Phone:
Surgeon:			
Oncologist:			
Radiation Oncologist:			
Plastic Surgeon:			
Other:			

I understand that the Lymphedema Foundation of South Florida (LFSF) provides services that are free and that all awards are made at the sole discretion of the LFSF. The information provided in this application is true. I release LFSF of all liabilities or claims whatsoever arising out of the provision of financial assistance and/or services provided or otherwise. I authorize LFSF to release my name, address, and type of assistance provided as required by law or to the Internal Revenue Service. I also authorize the release of any medical information and documentation required by LFSF for the purpose of verifying this application and I agree to sign any additional authorizations that may be required.

Applicant's Signature: _____ Date: _____

Print Name:_____

Name: _____

Lymphedema Foundation of South Florida

Patient History

Please describe briefly "How" and "Why" your Lymphedema developed_____

_____

_____

How long have you had Lymphedema? _____ Affected area: **Right / Left** arm **Right / Left** leg

Other_____

Do you have pain? (explain)_____

Any loss of function or mobility? (explain)_____

Do you wear a compression sleeve or stocking? _____

Did you ever use a compression pump? **Yes / No** (How long?)_____ Type: _____

Have you ever had any previous treatment for Lymphedema? _____

When: _____ Where: _____

Have you had any previous surgery? If "**yes**," list type and dates _____

_____

_____

Do you have any other medical problems? (i.e. diabetes…) _____

_____

_____

Have you had any Infections? **Yes / No** When?_____

Are you taking medications? If "**yes**", type and amount_____

Is there a family history of Lymphedema? **Yes / No ,** Do you exercise regularly? **Yes / No**

What are your goals from treatment?_____

_____

_____