Lymphedema Resources, Inc.
Post Office Box 1115
Estero, Florida 33929
www.lymphedemaresources.org
Tel: (844) 394-3154
Fax: (844) 394-3153
info@lymphedemaresources.org

Funding Request Processing Instructions

- Review the Eligibility Guidelines and Client Qualification Guidelines thoroughly.
- Complete the Funding Request Form – including the *two required signatures*
- Review the Checklist to assure *all attachments* are included in the submission
- Include garment measurement forms – arm or leg and the bandage list, if required
- Fax the completed package to 844/394-3153

If the request is approved, the requesting Certified Lymphedema Therapist will be notified by email. Garments and bandages are then ordered and shipped directly to the therapist. No garments/bandages are funded when ordered from any source not approved in writing in advance by Lymphedema Resources, Inc.

It is important to assure that all required attachments are included in the original request. Failure to do so will delay the approval process by up to 3 weeks.

All funding is made solely at the discretion of Lymphedema Resources, Inc.

Lymphedema Resources, Inc. is a 501c3 Federal tax exempt charity as defined by IRS rules.

May, 2015

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Lymphedema Compression Garments

Funding Assistance Requests
April 1, 2015 – March 31, 2016

Eligibility Guidelines (including 2015 Federal Poverty Guidelines)

Funding is available for underserved/underinsured individuals who require physician-prescribed compression garments for treatment of lymphedema.

To qualify, an individual must - -

Have valid photo identification with their current U.S. address (driver's license, gov't ID card)

Have a copy of their latest tax return (first two pages only). If no tax return is available, the applicant must have a pay/pension stub, social security statement for all working residents at the same address and a utility bill for the residence.

Be referred by a certified lymphedema therapist or physician

Have a current prescription for compression garments from a physician

Meet income guidelines:

Family Size	Annual Income	Monthly Income
1	$29,425	$2452
2	39,825	3319
3	50,225	2519
4	60,625	5052
5	66,025	5500

Note: Funding requests are evaluated on a case by case basis. ***One sleeve and/or one glove per limb and required bandages for each request.***

Please download funding request forms and instructions from www.lymphedemaresources.org, email us at lymphedemares@aol.com or call our office, 844/394-3154 to request a funding form by mail and instructions for requesting financial assistance. All inquiries are confidential and most welcome.

Income guideline is *250%* of Federal Poverty Guidelines published in the *Federal Register,* January 22, 2015.

Funding assistance awarded is solely at the discretion of Lymphedema Resources, Inc.

Lymphedema Resources, Inc.

Our mission as a community-based volunteer organization is to raise awareness of the potential for development of lymphedema, to assure availability of the resources for treatment and to eliminate barriers for those with lymphedema.

Client Qualification and Treatment Funding Guidelines

Clients requesting financial assistance are at or below 250% of the Federal Poverty Guidelines and must provide the following:

- government issued photo identification including their current address – driver's license, etc.
- current prescriptions for compression garments and/or lymphedema therapy from a physician
- tax return (first two pages) or income statement, pay or pension stub for ***all working residents*** at the same address and a utility bill for the residence (cable, electricity, telephone etc.)
- current insurance card for applications requesting co-pays
- funding assistance is requested by a physician or a certified lymphedema therapist on behalf of the client
- complete funding requests with two required signatures and ***all*** required attachments are submitted at the same time in one package

Funding for qualified applicants is provided as follows:

- bandages, one compression garment and one glove or gauntlet per limb per request with a maximum of two requests per year per client – 2 garments may be requested if dire need is validated by a certified lymphedema therapist
- lymphedema therapy for up to 10 sessions may be funded per request with a max number of 20 sessions per client per year (including co-pays) – ***sessions to start after approval is received***
- lymphedema therapy funding for treatment and co-pays is available **only** in Charlotte, Collier, Glades, Hendry and Lee Counties in Florida
- funding for lymphedema therapy or co-pays for Medicare/Medicaid-eligible clients is not provided
- clients canceling approved lymphedema therapy sessions are not eligible for any funding for one year
- requests for compression garments and lymphedema therapy for non-breast cancer applicants will be evaluated on a case-by-case basis depending on available funding at the time of the request

Lymphedema therapy providers must have a current signed "Letter Agreement for Funding of Lymphedema Therapy" on file with Lymphedema Resources, Inc. accepting $75 per lymphedema therapy session payment.

Incomplete applications are not considered for funding.

Approved by the Board of Directors, October 24, 2012, October 30, 3013, January 29, 2014

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Funding Approval Request – Lymphedema Therapy and Compression Garments

Name of the Certified Lymphedema Therapist or Physician: _____
Facility: _____
Address: _____
City/State/ZIP: _____
Phone: _____
Fax: _____
Email: _____

Client's Name: _____
Address: _____
City/State/ZIP: _____
Phone: _____
Email: _____
Date of Birth: _____

Requesting: bandages ____ compression garments ____ lymphedema therapy ____

Is the lymphedema a result of breast cancer? Yes _____ No _____
If no, what caused the lymphedema? _____
Affected limbs or area of the body: _____

****Does the client have medical insurance? Yes ____ No ____***
If yes, check below and attach copies of the documentation: Medicare ____ Medicaid ____ SSD/Disability ____
Public Assistance ____ Other Insurance ____

****Household Income Information:*** *Number in the household?* ____ *How many adults?* ___ *children (under 18)?* ____
Total Household Income? _____ *Currently employed?* Yes ____ No ____
Income sources: ***(attach copies)*** *Soc. Sec.* ____ *Pension* ____ *Unemployment* ____ *SSD/Disability* ____ *Other* ____

****Please attach copies of ALL of the following:***
Tax Return **(2 pages only)** ____ Driver's License ____ Cable/Utility Bill **(1 only)** ____ Current Prescriptions ____

****Please attach a completed garment measurement form and list of bandages requested.***
Number and type of compression garments requested? _____
Compression garments and bandages are shipped directly to the requesting healthcare professional.

****Number of lymphedema therapy treatments/or co-pays requested (SW Florida only):*** _____
Up to 10 (ten) lymphedema treatments are funded, **following approval**. If additional treatments are required, request additional approval ***before*** proceeding. ***Current Provider Letter*** on file? Yes ____ No ____

Client signature _____ ***Date*** _____

Healthcare professional _____ ***Date*** _____

Reference Eligibility Guidelines for 2015-16 for income qualification information.

Approved: _____ ***Date:*** _____ ***Comments:*** _____

Fax, email or mail signed, completed requests with ALL attachments as indicated above. We are unable to process incomplete funding requests. All information is strictly confidential and for our use only.

Approval of funding requests is done solely at the discretion of Lymphedema Resources, Inc.

Lymphedema Resources, Inc. is a 501c3 nonprofit charity under IRS rules. Our mission as a community-based volunteer organization is to raise awareness of the potential for the development of lymphedema, to assure availability of the resources for treatment and to eliminate barriers for those with lymphedema.

May, 2015 *** A response to all questions is required for the application to be considered for funding.**

Discount Medical Stockings

501 Goodlette Rd N Ste C-106 Naples FL 34102 800-809-0342
fax 888-872-6070 (239) 213-9474 (239) 213-9458

Bandage Order Form

Patient Name

Date of Order:

Referrer Fax (239) 437-1703

PO# Naples

Type of Bandage	Model	Size	Rolls per Case	Case Price	Broken Case Price	Number		Price
						Case	Rolls	
Rosidal K Short Stretch Bandages	90685	6 cm	20					
	90686	8 cm	20					
	90687	10 cm	20					
	90688	12 cm	20					
	90689	10 X 10	20					
Celona Under Padding	290400	4 inch	20					
	290600	6 inch	20					
Lohman Rosidal™ Soft Under padding	23111	10cm	20					
	23113	15cm	14					
Lohmann Komprex® Foam Rubber Padding	22313	5 mm thick	10					
	22301	0 Kidney	75					
Lohmann Tricofix Tubular Gauze	24004	6 cm	10					
	24006	9 cm	10					
	24007	12 cm	10					
Mollelast Finger Bandages	19410	4 cm	10 box case					
	19411	6 cm	10 box case					

Shipping UPS ground

Broken cases show A handling charge.

Subtotal	
Shipping	
Total Amount Due	

Discount Medical Stockings

501 Goodlette Rd N Ste C-106 Naples FL 34102

Arm Sleeve & Hand Portion Order Form

239-213-9458 / 800-809-0342 888-872-6070 FAX 239-213-9474

1 COMPLETE NAME first last

FLORIDA MAILING ADDRESS Zip code LOCAL PHONE ( )

NORTHERN ADDRESS NORTHERN PHONE ( )

DOCTOR'S NAME REFERRED BY

2 Current sleeve you are wearing: Arm affected: left right both E-Mail Address

To be completed with fitter

3 Armsleeve

- ☐ 3500 with full silicone
- ☐ 2000 with full silicone
- ☐ 3500 with shoulder strap
- ☐ 3500 with ¾ silicone

4 Gauntlet or Glove

- ☐ 3020 with thumb stub /Fingers
- ☐ 1101/2 thumb stub
- ☐ 2001/2 with thumb stub
- ☐ 1101 Fingers Mediven ccl 1 & 2 with Finger stubs

Circle sleeve compression ☐ 20-30 ☐ 30-40

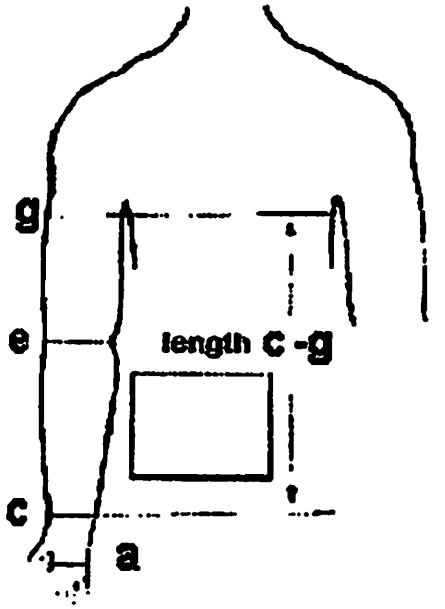
Circle # of sleeves ☐ 1 ☐ 2 ☐ 3 ☐ 4

Circle hand compression 20-30 30-40

Circle # of hands ☐ 1 2 ☐

5 Fill in Measurements

		Left		Right
Axilla largest g: circumference	g:		g:	
Elbow largest e: circumference	e:		e:	
Wrist smallest c: circumference	c:		c:	
Across metacarpus	a:		a:	



Discount Medical Stockings

501 Goodlette Rd N Ste C-106 Naples FL 34102

Leg Order Form

239-213-9458 // 800-809-0342 FAX 239-213-9474 // 888-8726070

1 COMPLETE NAME first last

FLORIDA MAILING ADDRESS Zip code LOCAL PHONE ( )

NORTHERN ADDRESS NORTHERN PHONE ( )

DOCTOR'S NAME REFERRED BY

2 Current garment you are wearing:

Leg affected: left right ☐ both ☐

E-Mail Address

To be completed with fitter

3 Circle length needed

- Calf ☐
- Thigh ☐
- Chaps ☐
- Pantyhose ☐

4 Circle compression needed

- ☐ support 8-20 mmHg
- ccl 1 20-30 mmHg
- ccl 2 30-40 mmHg
- ☐ ccl 3 40-50 mmHg

5 Shoe size

Height

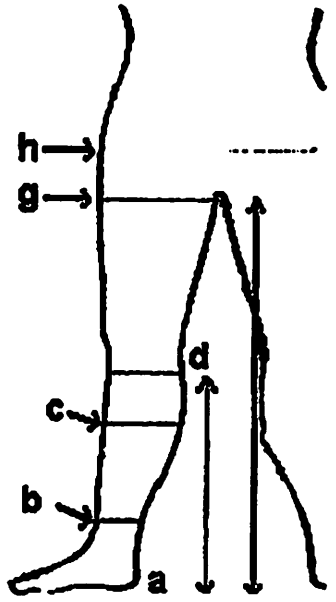
Weight

6 Circle diagnosis

- 457.1 lymphedema
- 443.9 peripheral vascular disease
- 451.0 phlebitis & thrombophlebitis
- 454.0 venous stasis ulcer
- 454.1 varicose veins w inflammation
- 459.8 venous peripheral insufficiency
- 782.3 edema edematous

7 Fill in boxes with measurements:

		Left		Right
Thigh largest circumference	g:		g:	
Calf largest circumference	c:		c:	
Ankle smallest circumference	b:		b:	
Length for calf high: (2 fingers below knee crease)	a-d			
Length for thigh high and panty hose	a -g			
Hip circumference: for pantyhose	h			



8 Number of Pairs: ____

9 Rubber Fitting Gloves $6

☐ small ☐ medium ☐ large

If known write:

Brand Size Color

Open –or– Closed toe

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To Certified Lymphedema Therapists –

The requesting certified lymphedema therapist is responsible for the completeness of the request for funding approval.

Please submit/fax the following checklist with the funding request for the client to assure that all required paperwork is attached. Failure to send the proper documents ***delays the request for up to three weeks.***

Documents to be included with the package at the time of the initial request:

Client's Name: _____

Checklist of items included in the package:

___ Funding request with two signatures

___ Current prescription(s) (one for garments, one for LE therapy)

___ Financial info (tax return - ***first two pages only or income statements etc)***

___ Driver's license copy (**enlarge the image and/or lighten copier to assure legibility**)

___ Utility or cable bill copy (***only 1 bill*** with name and address clearly shown)

___ Measurements form for arms or legs

___ Bandage list (if these are to be ordered by LRI)

___ Two signatures (client and requesting certified lymphedema therapist or physician)

I have reviewed the funding request and attachments for completeness:

_____

Signature/Date – requesting Certified Lymphedema Therapist or Physician

Note – ***No action is taken on incomplete funding requests***. We're eager to help your clients so be sure to submit a complete package.

May, 2015