LITTLE PEOPLE OF AMERICA
LPA HEALTH ADVOCACY FUND

APPLICATION FOR FUNDS

It is the intended primary purpose of the Little People of America, Inc., Health Advocacy Fund shall be to provide monies for a one-time use to assist LPA members in contributing toward their financial obligations for various dwarf-related medical expenses. The fund shall be used to provide assistance toward the remaining medical expenses after coinsurance, insurance deductibles, and other payments toward medical expenses have been applied. The intent is to not necessarily pay for all remaining eligible unpaid expenses, but rather to provide some financial assistance toward an individual's or a family's eligible unpaid expenses where demonstrated financial burden or need exists.

Examples of expenses for medical procedures that will be considered for assistance under this Fund (but are not limited to) are surgeries related to a specific dwarfism condition, placement/removal of shunts, decompression surgery, and orthopedic procedures. This Fund will not be used for cosmetic purposes or extended leg lengthening procedures.

Mail the complete form and enclosures to:

Bill Bradford
VP of Programs
Little People of America, Inc.
5289 NE Elam Young Parkway
Suite F-100
Hillsboro, OR 97124

If you have any questions, please feel free to call Bill at (541) 829-1315 or e-mail him at:

lpaprograms@gmail.com

Allocations for grants for the Fund to LPA members will be considered throughout each fiscal year. There will be no application deadline.

APPLICATION FOR LPA HEALTH ADVOCACY FUND (cont.)

Please type or print in ink. Continue on separate sheet(s) of paper if necessary.

Date:_____

Applicant's Name:_____

Address:_____

_____

City/State/Zip:_____

_____

Home Telephone Number:_____ Work Telephone Number:_____

E-Mail Address:_____

Age:_____ If the application is for a Little Person under 18 years of age, please state relationship to applicant:_____

LPA Chapter:_____ District:_____ Years of membership:_____

Type of dwarfism:_____

Brief description of dwarfism-related medical condition for which reimbursement is requested:_____

_____

_____

Date of medical procedure for which reimbursement is requested:_____

Name of doctor(s) who treated applicant for the above-referenced condition:_____

_____

Specialization:_____

Address:_____ City/State/Zip:_____

_____ Telephone Number:_____

Doctor's comments: **Enclose photocopy of doctor's report.**

APPLICATION FOR LPA HEALTH ADVOCACY FUND (cont.)

Name of primary medical insurance company:_____

Address:_____ City/State/Zip:_____

_____

Telephone Number:_____ Contact Person:_____

Name of secondary medical insurance company:_____

Address:_____ City/State/Zip:_____

_____

Telephone Number:_____ Contact Person:_____

1.) Total cost of above-referenced medical procedure(s) $ _____
(Attach copies of itemized bills and dates incurred)

2.) Total amount of payment by insurance company $ _____
(Itemize individual insurance payments, amounts, date paid -- use separate sheet if necessary)

3.) Total amount of deductible paid by applicant $ _____

4.) Total amount of payments (not including deductibles) made by applicant $ _____
(Itemize payments and date incurred -- use separate sheet if necessary)

5.) Total amount requested for reimbursement $ _____

APPLICATION FOR LPA HEALTH ADVOCACY FUND (cont.)

Describe reason given for denial or lack of insurance coverage/reimbursement. Enclose copy of notice of denial.

Describe any sources other than medical insurance company you have contacted and the results.

Describe any other assistance or support (i.e., family, church, community groups, March of Dimes, etc.)

Due to limited funds, the Bock Trust may only be able to pay one bill or a portion thereof. Please prioritize the bill(s) for which you are requesting funding to be considered by this trust fund.

The gross annual income* for your household at the time of the medical procedure for which

reimbursement is requested: $ _____

The current annual income for your household, if different $ _____.

* To figure gross annual income, add gross annual income received from work, plus untaxed income, according to your current IRS Form 1040.

Total number of dependents in your household claimed on your current 1040: _____

Were your medical expenses for the calendar year in question more than, or equal to 7.5% of your

adjusted gross income, as reflected on your 1040? _____

APPLICATION FOR LPA HEALTH ADVOCACY FUND (cont.)

Is there any other information you feel LPA should know in considering your application, including extenuating circumstances? Use separate sheet if necessary:

LPA will keep all documents submitted; please keep photocopies for your records. Your signature below demonstrates your understanding and consent that the documents submitted with this application and the information contained therein may be released to members of LPA Board of Directors, the members of LPA George Bock Charitable Trust Review Committee, and any independent medical and/or insurance professionals selected and consulted by the Committee, for assistance in interpreting medical and insurance information for the sole purpose of determining and awarding of funds.

Signature:_____

Date:_____