



Enabling patients who do not have insurance or the financial means to purchase the much needed lymphedema compression stocking(s)/sleeve(s) and alternative garments.

About the Fund

It is with tremendous pleasure that we introduce the NLN and Marilyn Westbrook Garment Fund. This is a dream that has come true not only for the NLN, but for our many patients who do not have insurance or the financial means to purchase the much needed compression stocking(s)/sleeve(s) and alternative garments. It was Marilyn Westbrook's choice to make sure that no other patients have to endure the pain and frustrations she went through six months prior to her passing (Dec 23, 2007). Marilyn and her husband Doyle donated a substantial amount of money to the NLN which will allow patients who qualify to pay for their garment(s). With the increased restriction of our health insurance and federal laws it is heartwarming to know that we will be able to assist a percentage of the many patients. This fund will help make sure patients wear the much needed garments to maintain their quality of life.

Review Process

Only complete applications will be reviewed, please be sure to include all the requested documents and answer all the questions in the Medical History section. You can email the application and requested documents or send it via regular mail, no faxes please.

All applications will be reviewed by a committee consisting of lymphedema therapists, lymphedema product company representatives and the NLN; all of your personal information will be kept confidential within the review committee. Please allow 2 - 4 weeks for review. You will be notified by mail of the decision. Please note: patients who are awarded garments will only receive one set of garment(s) per calendar year.

Requirements

- Patient must be a member of the National Lymphedema Network
- Patient must demonstrate genuine financial need
- Patient must complete a brief Medical History
- Patient must provide the completed medical necessity form from your current lymphedema therapist or physician stating the diagnosis, severity of the lymphedema and reason why the garment is medically necessary
- Patient must provide a brief (1 – 2 pages) biographical sketch detailing why he/she should be considered for the fund
- Patient must be receiving treatment at an NLN affiliated clinic or with an NLN affiliated therapist. Please contact the NLN office for a list of affiliated clinics and therapists.
- Patient must submit a \$25 non-refundable application fee



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GARMENT FUND

Marilyn Westbrook Garment Fund Application Form Cover Sheet

Each application should include this cover sheet and requested attachments.

NLN Member Number: _____

Applicant's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Outside USA
Foreign State: _____ Foreign Country: _____

Phone: _____ Fax: _____

Email: _____

Male Female

If patient is a minor, name of parent or guardian: _____

By signing here you acknowledge the release of your information (Personal information submitted will be stored confidentially and used only for purposes of application review and program evaluation.)
Please sign here: _____

Application Checklist

A copy of the prescription for your garment(s)

A letter of medical necessity from your treating lymphedema therapist or physician

\$25 non-refundable application fee paid for with credit card or check made directly to the National Lymphedema Network. Please be sure to write Marilyn Westbrook Fund in the Memo of the check.

A copy of the Explanation of Benefits (EOB) and/or denials from your insurance company

A completed application: cover sheet, financial need, health insurance information, medical history and brief biographical sketch





Financial Need

My annual household income is:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> \$1,000-10,000 | <input type="checkbox"/> \$31,000-35,000 | <input type="checkbox"/> \$51,000-55,000 | <input type="checkbox"/> \$71,000-85,000 |
| <input type="checkbox"/> \$11,000-20,000 | <input type="checkbox"/> \$36,000-40,000 | <input type="checkbox"/> \$56,000-60,000 | <input type="checkbox"/> \$86,000-95,000 |
| <input type="checkbox"/> \$21,000-25,000 | <input type="checkbox"/> \$41,000-45,000 | <input type="checkbox"/> \$61,000-65,000 | <input type="checkbox"/> \$96,000 or more |
| <input type="checkbox"/> \$26,000-30,000 | <input type="checkbox"/> \$46,000-50,000 | <input type="checkbox"/> \$66,000-70,000 | |

Number of family members supported by this income: _____

Is the annual household income provided solely by one individual or is this a joint salary range? _____

Income Source (please check all that apply and include details in your biographical sketch):

- | | | |
|--|--|--|
| <input type="checkbox"/> Social Security (retirement) | <input type="checkbox"/> Alimony | <input type="checkbox"/> Salary |
| <input type="checkbox"/> Pension | <input type="checkbox"/> Public Assistance | <input type="checkbox"/> Short Term Disability |
| <input type="checkbox"/> In-Kind (room and board) | <input type="checkbox"/> Child Support | |
| <input type="checkbox"/> Family/Friends provide support | <input type="checkbox"/> SSD (Disability) | |
| <input type="checkbox"/> Unemployment | <input type="checkbox"/> SSI | <input type="checkbox"/> Sick Leave Pay |
| <input type="checkbox"/> I am self-employed.
For how long? _____ Type of business: _____ | | |
| <input type="checkbox"/> I am currently employed:
Name of your employer/institution: _____
Your title/position: _____
How long have you been affiliated with above? _____ | | |
| <input type="checkbox"/> Other – Specify: _____ | | |



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Health Insurance Information

1) Do you have health insurance? Yes No

2) If yes, please indicate type of insurance (check all that apply):

- Medicaid Private Insurance Medicaid Pending
- Medicare Only VA Program Medicare plus Medicaid
- HMO Medicare plus other supplemental coverage
- Other: _____

3) What percentage of your garment costs does your insurance cover?

4) How much is your DME deductible? (US Dollars)

5) Have you met your DME deductible yet this year?

6) How much is your co-pay? (US Dollars)

Brief Medical History

Please complete the Medical History below; before submitting, be sure to include the requested documents. If needed, you may attach additional sheets

1) Age: _____

2) Type of lymphedema (please circle one):

primary

secondary (due to cancer, trauma, infection, other surgery, child birth, filariasis – please circle one)





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Medical History continued

3) If your lymphedema (LE) is cancer related:

Type of cancer – breast, gynecologic, prostate, melanoma, head and neck,
kidney, colon, other: _____

Year of surgery: _____

How long after your surgery did the LE present: _____

4) Affected area: Arms: _____ (please circle one) right left both

Legs: _____ (please circle one) right left both

Other area(s): _____ (please circle one) trunk abdomen genital

head and neck

5) Are you under the care of a certified LE therapist/clinic _____

Please provide their name, name of clinic (if applicable) address, phone number, email
address:

6) Are you currently wearing a compression or alternative garment? _____

If yes, please describe the, style, company and cost. Please also indicate if it is a
custom made or a standard general garment.

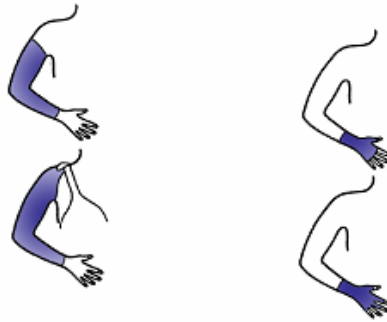


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Medical History continued

For assistance in describing the style, please see the images below and circle the one that most closely represents the garment you currently wear and indicate if it is a standard, custom or alternative garment.

VARIOUS STYLES OF COMPRESSION SLEEVES



VARIOUS STYLES OF COMPRESSION GARMENTS FOR THE LOWER EXTREMITY



7) Who prescribes your garment(s), your LE therapist or physician?

8) Please provide us with a copy of the prescription. Make sure this includes the name of the company, style and compression class (compression class only refers to garments).



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Medical History continued

9) How many garments do you use per year?

10) Who orders the garments, you or your therapist?

11) If you have insurance, what is their reason for denying payment of the garments?

12) Who bills the insurance you or your therapist?

13) Please provide use with a copy of an EOB of denial, if available.

Medical History continued

NLN



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14) How would you describe the severity of your condition?

15) Anything additional you would like to add. Please use additional sheets if necessary:



Brief Biographical Sketch



Medical Necessity Form

This form is to be filled out by the referring therapist and/or physician (please attach additional pages if necessary):

Patient Information

NLN Member Number: _____

First Name: _____

Last Name: _____

Therapist/MD Information

First Name: _____

Last Name: _____

Name of Clinic: _____

Mailing Address: _____

City: _____ **State:** _____

Zip/Postal Code: _____

Daytime Phone: _____ **Fax Number:** _____

Email address: _____

1. Patient's primary medical history:

2. Treatment diagnosis:

3. How severe is the lymphedema? (describe):





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Medical Necessity Form Continued

4. Is the patient disabled due to his/her lymphedema, and to what degree:
- Formal disability (i.e. SSI, employer disability) determination made, due to impact of lymphedema
 - Lymphedema significantly impairs patient's ability to work/perform ADLs
 - Effective management requires use of compression garment(s)

5. In your opinion, why is the garment medically necessary for this patient?

6. How would you rate this patient's compliance with therapy and/or garment wear in the past?

- Excellent
- Good
- Fair
- Poor

7. Other information (i.e. extenuating circumstances, history of infections, etc.):

Signature: _____ Date: _____