Lift Up Hemi, Inc.
Hemihyperplasia/Hemihypoplasia Charity

Lift Up Hemi - Inc. is a non-profit organization that provides assistance to individuals with Hemihyperplasia, Hemihypoplasia, BWS or any other disorder causing Hemihyperplasia.

- Applicants will be notified by mail within 60 days of postmark date to the status of their application.
- Applicants may re-apply 1 year after the original application was received.
- Funds are limited and based upon availability and applicant's need(s) and are in no way based upon race, creed or ethnicity.
- Financial Assistance may be in the form of a monetary payment to the applicant or a payment directly to a debtor. Forms of assistance will be decided on a case by case basis by the Board of Directors.
- Approval of this request grants a one-time assistance payment and does not promise future financial assistance.
- All information is held in the strictest confidence and is used only by Lift Up Hemi - Inc. for the purpose of reviewing financial assistance needs.

Please be sure to:

- Answer each question to the best of your ability and/or indicate if an item does not apply to your situation by stating "not applicable"
- Sign and date the application
- Have your doctor, nurse, or social worker complete the Medical Information section
- Provide current contact information where you can be reached to answer any additional questions if necessary.

Please mail application to:

Lift Up Hemi – Inc.
5 Homestead Drive
Cortland NY 13045

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PERSONAL INFORMATION

Date: _____

Applicant Full Name: _____
(Person with Hemihyperplasia/Hemihypoplasia)

Age at time of Application: _____ Date of Birth: _____

Parent/Guardian Full Name: _____
(If Applicant is under the age of 18)

Mailing Address: _____

City: _____ State: _____ Zip: _____

Country: _____ Home Phone: _____

Work #: _____ Cell #: _____

How did you hear about Lift Up Hemi - Inc.?
☐ Friend ☐ Co-Worker ☐ Facebook ☐ Internet ☐ Other: _____

Number of people living in your household: _____ Adults _____ Children

Health Insurance Carrier: _____

Have you previously applied for assistance from Lift Up Hemi - Inc.? ☐ Yes ☐ No

If yes, please indicate date and outcome of your application: _____

ASSISTANCE ASSESSMENT

For what purpose(s) are you seeking financial assistance? (check all that apply)

☐ Massage Therapy
☐ Medical Expenses
☐ Extended Leave of Absence from work due to Surgical Recovery
☐ Shoes
☐ Physical Therapy
☐ Travel Expenses for Consultation/Procedure
☐ Shoe Lifts/Shoe Inserts
☐ Other: _____

Please give a detailed, but brief, description on your intentions if funding is approved:

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MEDICAL INFORMATION

To be completed ONLY by Applicant's Doctor, Nurse or Licensed Social Worker

Diagnosis: _____ Date of Diagnosis: _____

Physician's Name: _____
(Primary Person Treating Applicant)

Practice/Hospital/Clinic Name: _____
(Primary location of Treatment)

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Signature: _____

Print Name: _____ Title: _____
(If different than Physician named above)

AGREEMENT AND SIGNATURE

After careful review of my completed application and by signing this document, I confirm that I am solely responsible for the accuracy of all information contained herein. I grant permission to the doctors and medical professionals contained herein to verify diagnosis with Lift Up Hemi - Inc. if needed and my medical information will be held in strict confidence. I understand that assistance approvals may sometimes result in general information being released and that my name will never accompany such release.

_____
Applicant's Signature

_____
Parent/Guardian Signature
(If Applicant is under the age of 18)