



MARILYN WESTBROOK
GARMENT FUND

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). 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, and the NLN; all of your personal information will be kept confidential within the review committee and stored at the NLN office. 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 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 provide the Medical Necessity Form completed by their NLN-affiliated therapist or physician.** This form can be found on the last 2 pages of this application.
- Patient must demonstrate genuine financial need
- Patient must complete the brief Medical History
- Patient must provide a brief (1 – 2 pages) biographical sketch detailing why he/she should be considered for the fund
- Patient must submit a \$25 non-refundable application fee

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Marilyn Westbrook Garment Fund Application Form Cover Sheet

Each application should include this cover sheet and requested attachments.

Applicant's 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 this application you acknowledge the release of your information (please note, your entire application will be kept confidential within the review committee). Please sign here: _____

Application Checklist

A copy of the prescription for your garment(s)

The Medical Necessity Form 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 Garment Fund in the Memo of the check.

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

A completed application: cover sheet, financial need, health insurance information, patient's medical history, brief biographical sketch, and Medical Necessity Form





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Financial Need

My annual household income is: \$ _____

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):

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

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Brief Patient's 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) Year of birth: _____

 - 2) Type of lymphedema (please circle one):
 primary secondary (due to cancer, trauma, infection, other surgery, child birth, filariasis – please circle one)

 - 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) Please provide the following information for your NLN-affiliated therapist/clinic: (required)
 Therapist's Name: _____
 Therapist's Clinic (if applicable): _____
 Therapist's Address: _____
 Therapist's Phone: _____
 Therapist's Email: _____





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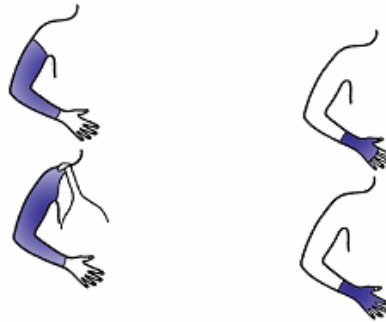
Medical History continued

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.

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? _____

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Medical History continued

8) Please provide us with a copy of the prescription. Make sure this includes the name of the company, style of compression class (compression class only refers to garments). Note that you can request this from your therapist or physician.

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.

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

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

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Brief Biographical Sketch

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Medical Necessity Form

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

NOTE: In order for a patient to qualify for the Marilyn Westbrook Garment Fund, the referring therapist and/or physician must be an NLN Affiliated Therapist, or be employed at an NLN Affiliated Clinic.

Patient Information

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 (select one):
- Formal disability (ie, 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, and other complications):

Signature: _____ Date: _____

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