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FACT SHEET

Financial Assistance for Prosthetic Services, Durable Medical Equipment, and Other Assistive Devices

by NLLIC Staff (Revised 2008)

Some of the questions most frequently asked by amputees who contact the National Limb Loss Information Center relate to the payment coverage for costs related to prosthetic fitting and associated services, and durable medical equipment (DME) such as wheelchairs, ramps, and other adaptive equipment. The prosthetic fitting process can be very costly depending on the difficulty of the case, pathology, and analogous components used - foot, ankle, knee, hip, hand, elbow, etc. Many durable medical devices such as sophisticated electronic wheelchairs are also very costly, and many people can experience financial hardship when trying to obtain these and other equipment needed to maintain their independence. Before attempting to find a funding source, two basic steps should be taken to lay the groundwork:

1. Determine what assistive device(s) you need — Those seeking to replace old or outdated equipment such as wheelchairs or crutches need to determine the specific item needed (make, model, manufacturer, etc.) and from where it will be purchased, and then get a prescription for the device. If there are changes in disability or ability levels, consult a therapist, physician, or rehabilitation professional to determine necessary features to accommodate them. For those who are newly disabled or in need of new prostheses, consulting with medical and rehabilitation professionals is the essential first step in the process.

2. Gather information — No matter where you seek assistance, organized information is important. Keeping the following documentation handy will help avoid frustration and unnecessary delays:

- Primary Disability (time of onset and cause of disability)
- Secondary Disability (time of onset and cause of secondary disability)
- Employment History
- Family Gross Income
- Monthly Expenses (rent or mortgage payments, utilities, outstanding loans and bills, medical expenses, etc.)
- Health Insurance Information
- Name, Age, and Relationship of Dependents

Preparing a Justification Statement

Some funding sources, particularly government programs, require the applicant to prepare a justification statement before funds are actually appropriated. Public or private insurance companies usually require the expected beneficiary, a physician, or a therapist to submit a statement of medical necessity for the purchase. State vocational rehabilitation agencies normally require that applicants demonstrate that the service or technology will enhance their ability to prepare for, get, or keep a job. If employment is not an expected outcome, then the justification statement must show that the device will enhance the individual's independence.

Other funding sources will have their own specific requirements. Success in securing funding frequently depends on the applicant's ability to address each agency's unique requirements. Sources of financial assistance range from Medicare and other insurance to national and local nonprofit organizations. The following is an overview of some of the available resources.

GOVERNMENT PROGRAMS

Medicare

In the United States, Medicare is the largest financial resource for prosthetic care. In addition to prostheses, Medicare commonly covers wheelchairs (both manual and power), walkers, and crutches. Ramps, adaptive driving devices, and other nonmedical devices are not covered.

In general, those eligible for Medicare include:

- People 65 years of age and older who are eligible to receive retirement benefits from Social Security or the Railroad Retirement Board, or their spouses.
- People under 65 years of age who have received Social Security or Railroad Retirement Board disability benefits for 24 months.
- People with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two Parts. Part A, for which most people do not have to pay, covers inpatient and outpatient hospitalization, home healthcare, some nursing home care, and hospice care. If you receive a prosthesis through one of these providers, the facility will often bill and receive payment directly from Medicare. Part B pays for professional services (physicians and other healthcare personnel), suppliers of medical devices and equipment (including artificial limbs), and certain outpatient services. If you receive prosthetic care outside of a facility setting, your prosthetist will bill Medicare Part B for you. Most people pay monthly for Part B. Note that if you do not have a Medicare supplement policy, you will be responsible for any co-pay (usually 20 percent) and deductible amounts. In addition, you may be responsible for the difference between the prosthetist's charge and the amount allowed by Medicare.

Obtaining SSD Medicare Coverage

For those under age 65, the first major obstacle to obtaining Medicare coverage for assistive devices may be getting approval for Social Security Disability (SSD) benefits. Approximately 70 to 75 percent of SSD applicants are denied the first time they apply. Persistence, detailed documentation of your medical history, and the help of an attorney are often the keys to receiving the benefits to which you are entitled.

In addition, most United States Congressional Representatives and Senators have staff caseworkers whose job is to provide assistance to their constituents who have problems with federal agencies and programs. However, these offices receive thousands of pieces of mail each week. In order to ensure that your correspondence receives the attention it deserves:

- Consult the Blue Pages of your local telephone book or go to www.house.gov/writerep to determine your Congressional district by zip code.

- Call the local office of your federal Representatives to determine whether the caseworkers are located in the state or in Washington, D.C.

- Place an initial phone call to the caseworker to establish a relationship and develop a personal contact. However, a written letter is typically required before an office is allowed to pursue action on your behalf.

Contacting one Representative's office is usually sufficient. However, if you do not receive the assistance you need from one office, try another.

When disability benefits are awarded, payment is typically made retroactive to the beginning date of either the disability itself or the medical condition that caused the disability. This retroactive date will also apply to the "waiting period" for Medicare eligibility.

L-Codes and Level II Modifiers

The "L-Code" system is the current method of billing Medicare for orthotic and prosthetic services. This is a unique medical billing "add-on" system, in which a base code identifies, and descriptive language explains, the basic approach taken. Various add-on codes describing multiple options in feet, knees, ankles, and other technology combines with the base code to fully describe the total services the patient is receiving and what is covered by Medicare.

Additionally, Level II, or "K-Modifiers" help organize components and amputees' access to them based on the patient's rehabilitation potential as determined by the prosthetist and ordering physician. Criteria considered for assessing the functional level include the patient's history, current condition including the status of the residual limb and the nature of other medical problems, and the patient's desire to ambulate. Classification levels are:

- K0 (Level 0) - Does not have the ability or potential to ambulate or transfer safely with or without assistance, and a prosthesis does not enhance the quality of life or mobility.

- K1 (Level 1) - Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence — typical of the limited and unlimited household walker.

- K2 (Level 2) - Has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs, or uneven surfaces — typical of the limited community walker.

- K3 (Level 3) - Has the ability or potential for walking with variable cadence — typical of the community walker who is able to traverse most environmental barriers and may have vocational, therapeutic or exercise activity that demands prosthetic use beyond simple walking.

- K4 (Level 4) - Has the ability or potential for prosthetic use that exceeds basic walking skills, exhibiting high impact, stress or energy levels — typical of the prosthetic demands of the child, active adult, or athlete.

The following determination of coverage for selected prostheses and components with respect to potential functional levels represents the usual case. Exceptions are considered in individual cases if additional documentation is included that justifies the medical necessity. Prostheses are denied as not medically necessary if the patient's potential functional level is "0".

Feet:

- Basic lower-extremity prostheses include a solid-ankle cushion-heel (SACH) foot.
- External keel, SACH foot or single-axis ankle/foot are covered for patients with a functional Level 1 or above.

- Flexible-keel foot and multiaxial ankle/foot candidates are expected to demonstrate a functional Level 2 or greater functional needs.
- Flex-foot system, energy-storing foot, multiaxial ankle/foot, dynamic response, or flex-walk system or equal are covered for patients with a functional Level 3 or above.

Knees:

- Basic lower-extremity prostheses include a single-axis, constant friction knee.
- Fluid and pneumatic knees are covered for patients with a functional Level 3 or above.
- Other knee systems are covered for patients with a functional Level 1 or above.

Ankles:

- Axial rotation units are covered for patients with a functional Level 2 or above.

The following are general policies regarding coverage of prosthetic sockets:

- Test (diagnostic) sockets for “immediate prostheses” are not medically necessary.
- No more than two test sockets for an individual prosthesis are medically necessary without additional documentation.
- No more than two of the same socket inserts are allowed per individual prosthesis at the same time.
- Socket replacements are considered medically necessary if there is adequate documentation of functional or physiological need. The Durable Medical Equipment Regional Carrier (DMERC) recognizes that there are situations where the explanation includes but is not limited to changes in the residual limb, functional need changes, or irreparable damage or wear/tear due to excessive patient weight or prosthetic demands of very active amputees.

When Your Claim is Denied

If your Medicare claim is denied, it is important to understand why and what options you have. Reasons for denial of claims for durable medical equipment (DME) and prosthetic devices usually fall into five categories:

1. Lack of medical necessity — If your claim was denied for this reason, you should appeal the denial. The appeals process must be initiated within six months of the processing date of Remittance Advice. There are five levels of appeal:

   a) Review — The appeals process is begun by submitting a HCFA 1964 form or a written letter of request. Any additional information, along with all the originals, will be examined by a reviewer who did not participate in the initial decision.

   b) Fair Hearing — If the original decision is upheld and your case is valued at $100 or more, you may submit, in writing, a request for a Fair Hearing within 120 days of the Review decision. You can request that the hearing be conducted in person or by phone. A date and hearing officer is assigned to the claim. Before the hearing date, the officer will conduct an "on the record" review of the case and any supporting documentation. The officer has the authority to conclude the case at this point or, if the review is not favorable, the scheduled hearing will be conducted.

   c) Administrative Law Judge — Claims denied in the Fair Hearing and valued over $500 can proceed to this level. The request must be submitted in writing within 60 days of the Fair Hearing decision.

   d) Appeals Council and Judicial Review — Claims must be valued over $1000 to be eligible for these levels, and each requires filing within 60 days of the previous decision. Claims that are denied in review and do not meet the dollar limit for the next level have no further appeal options.

   e) Each appeal level will put your claim before an entirely new set of people. While you may submit additional documentation at any level, it is important that you do not delete any previously submitted material. It is also in your best interest to personally verify that all previously reviewed information is transferred to the next level.

2. Non-Covered Services — Medicare has excluded these items from its list of covered services. No appeals process is available.

3. Incomplete Information — Many claims are returned for missing information. The reason code on your Remittance Advice form will not identify what is missing, so you will need to pay very close attention to each detail to ensure that nothing is overlooked. Not Otherwise Specified (NOS) coding, used when a service is provided that cannot be described with an existing code, is another cause of claim denials. Adequate documentation must be included with these codes so that Medicare can determine the appropriateness and reimbursement level for the procedure or device.

4. Duplicate Submission — Claims denied for this reason should be investigated immediately. Contact Medicare to determine why this reason was given. If the claim was indeed resubmitted, find out what happened to the original claim.

5. Not Separately Payable — Claims denied because the service was considered to be included in another code usually cannot be appealed. If you feel the interpretation is incorrect, you may present the case to your ombudsman, whose job is to assist you with difficult cases.

Your primary source of assistance with appeals and resubmission of denied claims will be your provider's administrative staff. It is in your best interest to have them do this for you. If necessary, you may want to ask them to do so. In order to provide this service for you, your provider will need your signature authorizing his staff to represent you in any needed claims review.

If you have questions about Social Security, call toll-free at 800/772-1213 or visit their local office search at https://s044a90.ssa.gov/apps6z/FOLO/fo001.jsp.

Medicaid

Medicaid is a jointly funded, cooperative venture between the federal and state governments to assist states in providing adequate medical care to eligible individuals. Within broad national guidelines that the federal government provides, each of the states:

- establishes its own eligibility standards.
- determines the type, amount, duration and scope of services.
- sets the rate of payment for services.
- administers its own program.

Thus, Medicaid eligibility and covered services vary considerably from state to state, as well as within each state over time. Unfortunately, coverage for prosthetic care is not mandated, and therefore ranges from reasonably good to nonexistent.

To be eligible for federal funds, states must provide Medicaid coverage for most individuals who receive federally assisted income maintenance payments, as well as for related groups not receiving cash payments. Some examples of the mandatory Medicaid eligibility groups are:

- low-income families with children.
- Supplemental Security Income (SSI) recipients.
- infants born to Medicaid-eligible pregnant women.
- children under age 6 and pregnant women whose family income is at or below 133 percent of the Federal poverty level (states are required to extend Medicaid eligibility until age 19 to all children born after September 30, 1983).
- recipients of adoption assistance and foster care.
- certain Medicare beneficiaries.
- special protected groups who may keep Medicaid for a period of time, including: people who lose SSI payments due to earnings from work or increased Social Security benefits; and families who are provided 6 to 12 months of Medicaid coverage following loss of eligibility under Section 1931 due to earnings, or 4 months of Medicaid coverage following loss of eligibility under Section 1931 due to an increase in child or spousal support.

For people who may have too much income to meet the mandatory eligibility requirements or those adopted by their state, many states have a "medically needy" program. This option allows them to "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income, or by paying monthly premiums to the state in an amount equal to the difference between family income and the eligibility standard.

For information about your state's version of the Medicaid program, contact your state's administering agency, usually the Department of Human Health and Social Services, the Department of Human Services, or the Department of Medical Assistance. Phone numbers for these agencies can be found in the Blue Pages of your telephone directory. You may also want to visit www.cms.hhs.gov/RegionalOffices for a regional listing of Medicaid offices.

Help to Pay Your Healthcare Costs

Most of your healthcare costs are covered if you have Medicare and you qualify for Medicaid. States also have programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain people who have Medicare and a low income. To qualify, you must have:

- Part A (Hospital Insurance).
- assets such as bank accounts, stocks, and bonds that are not more than $4,000 for a single person, or $6,000 for a couple.
- a monthly income that is below certain limits.

There are also prescription drug assistance programs available. These programs offer discounts or free medications to individuals in need. For more information on these programs, call your nearest medical assistance office. You can find the number in the phone book under Medicaid, Social Services, Medical Assistance, Human Services, or Community Services. Or you can call the Medicare information line at 800/633-4227 (800/MEDICAR); a Medicare customer service representative can help you find the right office in your state.

Veterans Administration

The Veterans Health Administration (VHA) provides a broad spectrum of rehabilitative care to its beneficiaries, including a fairly wide array of prostheses, mobility devices such as wheelchairs, and adaptive driving equipment. In addition to coverage for veterans themselves, the VA provides needed healthcare benefits, including prosthetic devices, medical equipment, and supplies to certain children of Vietnam veterans (i.e., children suffering from spina bifida or an associated disability). Veterans may also receive VA healthcare benefits including prosthetics and medical equipment through participation in the VA's vocational rehabilitation program. Veterans outside of the United States, with certain exceptions, are only eligible for prosthetics, medical equipment, and supplies for a service-connected disability.

In order to be eligible for enrollment for healthcare, you must have:

- been discharged from active military service under honorable conditions.
- served a minimum of two years if discharged after September 7, 1980 (prior to this date, there is no time limit).
- served as a National Guard member or reservist for the entire period for which you were called to active duty, other than for training purposes only.

VA healthcare enrollment is a new system providing access to a comprehensive package of services. If you want to use the VA healthcare system, you must fill out the VA form 10-10EZ unless:

- the VA rates you as having a service-connected disability of 50 percent or more.
- it has been less than one year since you were discharged from military service for a disability that the military determined was incurred or aggravated in the line of duty, and have not yet been rated by VA.
- you are seeking care from VA for a service-connected disability only.

The 10-10EZ form may be obtained by visiting, calling, or writing any VA healthcare facility or veterans' benefits office, or by calling toll-free 877/222-8387 (877/222-VETS). You can also access the form on the Internet at www.va.gov/vaforms.

The form should be forwarded to your nearest VA healthcare facility for processing. Once you apply for enrollment and your application eligibility is verified, you will be assigned a priority group (ranging from 1 to 7, with 1 being the highest priority for enrollment) based on your specific eligibility status. Enrollment will be reviewed and renewed each year depending upon your priority group and available resources. If sufficient funding is not available for the VA to renew enrollment for your priority group for another year, you will be notified in writing before your enrollment period expires. Under the Uniform Benefits Package, the same services are generally available to all enrolled veterans, including treatment for both service-connected and non-service-connected disabilities.

Artificial limbs must be prescribed by a designated physician/podiatrist of the VA's Amputee Clinic Team or the Prosthetic Representative. Devices may then be fabricated and fitted by VA hospitals or clinics, private prosthetic facilities on contract with the VA, or, under certain circumstances, by non-contract prosthetists. While the VA prefers that patients use either VA facilities or private facilities under contract with the VA, veterans who have previously received artificial limbs from commercial sources may continue to receive services from their non-contract prosthetist, providing the prosthetist will accept the VA preferred provider rate for the geographic area. Veterans may also receive services from non-contract vendors when a prescribed limb or component is not available through VA or contract facilities.

Recreational artificial limbs, which allow an amputee to participate in a specific recreational or athletic activity, may be provided. The following are general guidelines regarding the issue of recreational prosthetic appliances:

- The physician or podiatrist of the Amputee Clinic Team must prescribe the prosthesis.
- The prescription must indicate the therapeutic, rehabilitative, or psychological benefit to be expected or achieved through participation in this specialized activity. The prescription must indicate that a conventional prosthesis that is worn daily is unsuitable for use in the recreational activity, either because of environmental factors that would affect the prosthesis or because a specialized function not available in the conventional limb is required in the activity.

For more information, visit the VA Web site at www1.va.gov/health or call the VA Health Benefits Service Center toll-free at 877/222-8387 (877/222-VETS).

TRICARE

TRICARE is the Department of Defense's worldwide healthcare program for active duty and retired uniformed service members and their families. TRICARE options include TRICARE Prime, a managed care option;

TRICARE Extra, a preferred provider option; and TRICARE Standard (the old CHAMPUS program), a fee-for-service option. TRICARE for Life is also available for Medicare-eligible beneficiaries age 65 and over.

Eligible family members include:

- spouses and unmarried children, including stepchildren.
- those under age 21 (age 23 if full-time student) of active and retired service members.
- un-remarried spouses and unmarried children of deceased service members.
- spouses and unmarried children of reservists and retired reservists.
- Medal of Honor recipients and their family members.
- former spouses of active duty or retired service members, under certain circumstances.

Dependent parents and parents-in-law are only eligible for TRICARE Plus, a local military treatment facility (MTF) -based primary care enrollment program that may provide coverage for primary care services. They are also eligible for the Senior Pharmacy Program if they meet all of the requirements. The following is a brief overview of the available TRICARE programs.

TRICARE Prime is similar to a health maintenance organization (HMO). Prime enrollees choose a Primary Care Manager (PCM). The PCM becomes the beneficiary's primary physician for the duration of his or her enrollment in the program unless changed by the beneficiary by contacting a Beneficiary Service Representative at your TRICARE Service Center. Military retirees and their dependents pay an annual enrollment fee of $230 for an individual or $460 for a family. Active duty family members enroll for free. Active duty service members must enroll in Prime. Active duty family members, retirees and their family members are encouraged, but not required, to enroll in Prime.

TRICARE Prime offers several benefits:

- no enrollment fees, deductibles, or co-payments for active duty members and their families
- $230 enrollment fee ($460 for families) and minimal co-payments for retirees
- limits on appointment wait time
- limits on driving time from home to obtain care
- limit on office waiting time of 30 minutes for non-emergency situations.

Prime also offers a "point-of-service" option for care received outside the TRICARE Prime network; however, receiving care from a nonparticipating provider is not encouraged.

Members whose permanent duty assignment (and residence) is 50 miles or more from an MTF or other sources of military healthcare are eligible for TRICARE Prime Remote (TPR). TPR provides no-cost healthcare for active duty members. A new interim Waived Charges benefit for family members dispenses with out-of-pocket expenses. TPR is only available in the United States.

TRICARE Extra and TRICARE Standard are ideal for individuals who prefer greater flexibility in physician choice, since beneficiaries do not have to select a Primary Care Manager (PCM) physician and can be seen by any TRICARE authorized provider. No enrollment fees or forms are required for TRICARE Extra or Standard. Beneficiaries are responsible for annual deductibles and cost-shares. Deductibles are $50 or $100 per year for individuals and $150 or $300 for families, depending on the service member’s grade. Maximum out-of-pocket expense is $3000 per enrollment or fiscal year.

TRICARE Extra is a preferred provider option (PPO) in which beneficiaries choose medical providers within the TRICARE provider network. TRICARE Standard is a fee-for-service option, which allows you to see an authorized provider of your choice. People who are happy with service from a current civilian provider often choose this option. However, cost-shares are 5 percent more plus the difference between the TRICARE allowable charge and the doctor's billed charge.

TRICARE For Life (TFL) is for beneficiaries who have become eligible for Medicare. These beneficiaries are ineligible for TRICARE Prime but are eligible to use network and non-network providers under TRICARE Extra and Standard. There are no enrollment fees for TRICARE For Life. You are required to enroll in Medicare Part B and must pay Medicare Part B monthly fees. Enrollees also pay cost shares for services not payable by Medicare. The following groups are eligible to enroll in TFL:

- Medicare-eligible uniformed service retirees, including retired National Guard members and reservists
- Medicare-eligible family members, including widows/widowers
- Certain former spouses if they were eligible for TRICARE before age 65.

The Continued Health Care Benefit Program (CHCBP) temporarily provides the same benefits as TRICARE Standard for military personnel who are discharged or released from active duty (under other than adverse conditions). Family members, emancipated children, and, in some cases, former spouses who have not remarried are also eligible. CHCBP coverage is available for 18 months. An unmarried dependent child or a former spouse who has not remarried may be eligible for coverage for 36 months. Typically, you must enroll during the 60-day period that begins at the time of discharge or loss of eligibility for care under the Military Health Services System in order to receive benefits. The premiums for this coverage are $933 per quarter for individuals and $1,996 per quarter for families. The CHCBP benefits are comparable to the TRICARE Standard benefit, which covers a majority of medical conditions, uses existing TRICARE providers, and follows most of the rules and procedures of TRICARE Standard. For more information about this program, you can visit www.humana-military.com/chcbp/main.htm or contact:

Humana Military Healthcare Services, Inc.
Attn: CHCBP
PO Box 740072
Louisville, KY 40201
800/444-5445

For more information regarding any of the TRICARE programs, contact your TRICARE Service Center or visit the military's TRICARE Web page at www.tricare.osd.mil or Palmetto Government Benefits Administrators' TRICARE page at www.mytricare.com.

Vocational Rehabilitation

Most states have vocational rehabilitation programs that provide assistance to people with limb loss or other disabilities in obtaining and keeping employment; or if a prosthesis or other adaptive device is designated as a daily living aid. These programs vary widely from state to state as to eligibility requirements and services. Some may fund prosthetic care if it is determined to be necessary for employment, or if the device allows for greater independence. Assistive devices such as wheelchairs, lifts, and adaptive driving equipment are often

furnished to enable a person to get to the job site. Devices necessary for job performance also are usually provided.

The telephone number for your state's vocational rehabilitation office can be found in the Blue Pages of your local directory. You may also want to perform an Internet search for contact information and links to your state vocational rehabilitation agency's Web site, which should provide an overview of their services. You can also locate your state's vocational rehabilitation program information by accessing the following Web site: www.jan.wvu.edu/SBSES/VOCREHAB.HTM.

State Technology Assistance Projects

This program, originally funded under the Technology-Related Assistance for Individuals with Disabilities Act of 1988, supports statewide, comprehensive, technology-related assistance for individuals of all ages with disabilities. State projects typically provide assistance in choosing and acquiring equipment, whether acquired commercially off the shelf, modified or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. Each state, within federal guidelines, determines what services it provides. Some services frequently provided are:

- information and referral.
- product demonstration.
- equipment recycling and loan programs.
- device modification.
- low-interest loan programs.
- advocacy in obtaining funding for devices.

A few states' programs provide direct financial assistance to individuals in need of various types of adaptive equipment, including prostheses, and some have loan programs; others provide no funding at all to individuals. Most do have information and referral services, and may be able to direct you to local sources of financial assistance for which you qualify. The telephone number for your state's program may be found in the Blue Pages of your local directory. A listing of state assistive technology projects, complete with contact information and links to Web pages, may be found on the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Web site at www.resna.org/taproject/at/statecontacts.html.

Protection and Advocacy (P&A) / Client Assistance Program (CAP)

In an effort to address public outcry in response to the abuse, neglect, and lack of programming in institutions for people with disabilities, Congress created a system in each state and territory that provides protection of the rights of people with disabilities through legally based advocacy. The governor in each state designated an agency to be the Protection & Advocacy (P&A) system and provided assurance that the system was and would remain independent of any service provider. This federally mandated system includes several programs. Those most likely to be of assistance to people with limb loss are:

- The Protection and Advocacy for Individual Rights (PAIR) Program—established to protect and advocate for the legal and human rights of all people with disabilities.

- The Protection & Advocacy for Assistive Technology (PAAT) Program—created to assist individuals with disabilities and their family members, guardians, advocates, and authorized representatives in accessing technology devices and assistive technology services through case management, legal representation, and self-advocacy training.

The Client Assistance Program (CAP) was established by 1984 Amendments to the Rehabilitation Act as a condition for receiving allotments under Section 110. CAP services include assistance in pursuing administrative, legal, and other appropriate remedies to ensure the protection of people receiving or seeking services under the Rehabilitation Act.

If you have received unsatisfactory services or have been denied services to which you believe you are entitled under federally funded programs, your state's P&A or CAP should provide assistance. Telephone listings for these agencies may not be available in your local directory. Call the Rehabilitation Services Administration at 202/245-7488 or visit their Web site at www.ed.gov/about/offices/list/osers/rsa.

Private Insurance

Coverage for prosthetic care and DME varies widely from one insurance company to another and can also differ with various policies offered by a given company. Coverage can range from all medically necessary devices for life to no coverage at all. While it is impossible to provide specific information about the many health insurance companies currently in business, there are some basic things to consider when selecting an insurance policy. You should ask about:

- eligibility requirements.
- preexisting condition clauses.
- devices that are covered (get something in writing to ensure that artificial limbs are covered).
- coverage limits.
- limits on the number of items per year or per lifetime.
- the rate of payment (should be at least comparable to Medicare rates).
- the Preferred Provider Network (is your current prosthetist included?).

The Georgetown University Health Policy Institute provides HealthInsuranceInfo.net, with information on insurance regulations for every state.
www.healthinsuranceinfo.net

Many health insurance companies have their own Web sites that offer specific information about their policies. In addition, there are several Web sites that inform consumers and help them compare health insurance companies and policies. Some of these are:

- Insure.com - www.insure.com/health
- INSWEB - www.insweb.com
- netQuote - www.netquote.com

Insurance Problems

If you have problems getting the coverage to which you are entitled from your insurance company, the most valuable source of assistance is your state department of insurance. This office is located in the capital city of each state and the telephone number should be in the Blue Pages of your local directory. Insurance commissioners can take action against insurance companies, agents, and brokers. They are empowered to conduct investigations, acquire records relevant to your case, issue orders, hold hearings, and suspend and revoke licenses. Contact information for your state's department of insurance may also be found on the National Association of Insurance Commissioners Web site at www.naic.org/state_web_map.htm.

Medical Discount Programs

Medical discount programs are relatively new on the healthcare scene. These companies negotiate with PPO providers for their members to receive discounts on medical goods and services ranging from prescription drugs to office visits to nursing home care. While DME is often included in the benefits packages provided in the programs, prosthetic care is not usually specifically mentioned.

The programs' advantages to the provider are immediate payment, less paperwork, and no "red tape" in getting approval for services provided. Advantages to the patient are discounted medical fees, no deductibles and no preexisting condition clauses, unlimited use of services, no claim forms to fill out, and relatively low "premiums" or fees.

Most of the companies stress that this is not insurance and should not replace existing insurance. However, for those who are uninsurable or cannot afford insurance coverage, this may be an alternative worth investigating. Since all of these companies are relatively new and have not established an extensive track record, it would be wise to thoroughly check out any company before making a commitment. Read all the fine print, make sure all of your questions are answered to your satisfaction, and consider consulting the Better Business Bureau to see if complaints have been registered.

Nonprofit Organizations

The following organizations provide assistance to people who otherwise are unable to afford prosthetic care. Some provide other services as well. Each organization has its own method of providing services and requirements for eligibility. If you do not qualify for one program, you may be eligible for another, so don't give up!

Barr Foundation

136 NE Olive Way
Boca Raton, FL 33432
561/391-7601
foundation@t-barr.com
www.oandp.com/resources/organizations/barr/

This fund pays for materials and fitting of a new prosthesis after the prosthetist has established that there are no other sources of funding available. The Barr Foundation also accepts used prosthetic devices. Please call the Barr Foundation for further information.

Bowman Siciliano Limb Bank Foundation

100 Spanish Oak RD
Weatherford, Texas 76087
817/597-1826
LimbBank@danabowman.com
www.danabowman.com/danabowman122006_032.htm

The Bowman Siciliano Limb Bank Foundation acts as a ready resource for artificial limbs for those in need. It is a non-profit organization seeking to fulfill the need for artificial limbs in underdeveloped nations and here in the United States where traditional funding is unavailable.

Challenged Athletes Foundation

11199 Sorrento Valley RD, STE C
San Diego, CA 92121
858/866-0959
caf@challengedathletes.org
www.challengedathletes.org

The Challenged Athletes Foundation raises money to help people with physical disabilities pursue an active lifestyle through physical fitness and competitive athletics.

Limbs for Life Foundation

5929 N May, STE 511
Oklahoma City, OK 73112
405/843-5174 or 888/235-5462 (toll-free)
admin@limbsforlife.org
www.limbsforlife.org

Each qualified applicant will be provided with partial or complete funding for an advanced prosthesis, fitted by a highly qualified prosthetist

Life Without Limbitations Foundation

P.O. Box 96
Lake Bluff, IL 60044
847/946-8306
limbitations@comcast.net
www.lifewithoutlimbitations.org

Life Without Limbitations is a non-profit organization dedicated to providing prosthetic care for individuals, principally children, who cannot otherwise afford it and raising awareness of the challenges facing amputees. Currently assisting people only in the United States.

Limbs for Life Foundation

5929 N May, STE 511
Oklahoma City, OK 73112
405/843-5174 or 888/235-5462 (toll-free)
admin@limbsforlife.org
www.limbsforlife.org

Each qualified applicant will be provided with partial or complete funding for an advanced prosthesis, fitted by a highly qualified prosthetist.

Limbs of Hope Foundation

6782 S Dixie DR
West Jordan, Utah 84084
801/548-0553
donate@limbsofhope.org
www.limbsofhope.org

The Limbs of Hope Foundation accepts new and used prosthetics that are to be sent across the globe in hopes of bettering the quality of life for those in need. They also provide recreational opportunities and recreational equipment for underdeveloped countries, as well as remodeling clinics in countries torn by war and/or illness.

Limbs of Love

1000 S Loop West STE 150
Houston, TX 77054
713/747-7647
www.limbsoflove.com

Limbs of Love utilizes the time, skills and resources of medical professionals and manufacturers who receive no remuneration in an effort to improve the overall quality of life for amputees, primarily in Texas.

National Amputation Foundation
40 Church ST
Malverne, NY 11565
516/887-3600
amps76@aol.com
www.nationalamputation.org

The National Amputation Foundation (NAF) has for over 80 years been offering valuable assistance to veterans of World War I, II, Korea, the Vietnam Conflict, Desert Storm and Iraqi Freedom. Since then, the Foundation has expanded its facilities to include civilian amputees as well.

Local Service Clubs

Lions, Rotary, Elks, Shriners, or any other fraternity or special interest groups in your community could provide dollars or assistance in fundraising. Please contact the respective organization for further information.

Children's Services

Programs for Children with Special Healthcare Needs

In 1988, then surgeon-general, Dr. C. Everett Koop, introduced a National Agenda for Children with Special Health Care Needs (CSHCN). In 1989, this agenda was translated into legislation through Title V of the Social Security Act, which requires state CSHCN programs to provide and promote family-centered, community-based, coordinated care for children with special healthcare needs and to facilitate the development of community-based systems of services for such children and their families.

Each state has a Title V CSHCN program administered through the Department of Health and Human Services by agencies called Children's Special Needs Services, Children's Medical Services, or similar names. Under the Title V legislation, children with special healthcare needs include all children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions, and who also require health and related services of a type or amount beyond that generally required by children. A directory of state Title V CSHCN programs, along with information regarding eligibility and services is available online at cshcnleaders.ichp.edu/TitleVDirectory/directory.htm.

State Children's Insurance Program

The State Children's Health Insurance Program (SCHIP) is the largest expansion of health insurance coverage for children in over 30 years. SCHIP enables states to insure children at little or no cost to working families with incomes too high to qualify for Medicaid, but too low to afford private coverage. The initiative is a partnership between the federal and state governments that will help provide children with the health coverage they need to grow up healthy and strong. You can get information about this program by calling 877/543-7669 or by visiting the Insure Kids Now Web site at www.insurekidsnow.gov.

Administration for Children and Families (ACF)

The Administration for Children and Families (ACF), within the Department of Health and Human Services (DHHS), is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities. Among these is the Temporary Assistance for Needy Families (TANF) program, which replaced the Aid to Families with Dependent Children and the Job Opportunities and Basic Skills Training programs. States, territories, and tribes determine eligibility and benefit levels and services provided to needy families. For more information on ACF programs, contact your DHHS office or visit the ACF Web site at www.acf.dhhs.gov.

Shriners Hospital

Shriners Hospitals for Children, a network of hospitals that provide expert, free orthopedic and burn care to children under 18, is the Shrine of North America's official philanthropy. Shriners Hospitals are open to all children without regard to race, religion, or relationship to a Shriner. Any child may be eligible for care at Shriners Hospitals if:

- the child is under the age of 18.
- there is a reasonable possibility the child's condition can be helped.

The service area of Shriners Hospitals includes the United States, Canada, and Mexico. Special procedures must be followed for those applying from outside one of these countries.

Application forms for admission to Shriners Hospitals may be obtained:

- from any Shrine Temple or Shrine Club.
- by calling the Shriners Hospitals toll-free referral line at 800/237-5055.
- from the Shriners Web site at www.shrinershq.org/Hospitals/_Hospitals_for_Children/Admission/patient_applications.aspx.

St. Jude Children's Hospital

Children may receive prosthetic care at St. Jude's in conjunction with treatment of a catastrophic illness such as osteosarcoma. Acceptance for treatment is based solely on a patient's eligibility for an ongoing clinical trial at St. Jude Children's Research Hospital. To determine if your child is eligible, your child's physician must:

- call the referral line at 866/278-5833.
- fax relevant information to 901/495-4011.
- complete a referral online at www.stjude.org/Forms/physicianReferralRequest.

Blue Cross/Blue Shield

Some Blue Cross/Blue Shield companies have established “Caring for Children Foundations” that provide free or low cost coverage to children who are not insurable through Medicaid or private insurance. Some of these foundations work with the SCHIP programs in their states. Others work independently and accept no government funding. Services and eligibility requirements vary. Call your local Blue Cross/Blue Shield office or visit the national Web site at www.bcbs.com to find out if such a program exists in your area.

Variety—The Children’s Charity of the United States

Variety bills itself as the largest children's charity in the world, with 51 chapters in 13 countries. Dedicated to improving the quality of life of children who are less fortunate than others, the traditions of Variety are rooted in show business and the circus. The members, largely drawn from the world of entertainment, leisure, media and business, work to assist children who may be sick, handicapped, or disadvantaged by social circumstances. For more information, contact:

Variety of the United States
5757 Wilshire BLVD, STE 445
Los Angeles, CA 90036
323/954-0820
info@usvariety.org
www.usvariety.org

Other Information Sources

AgrAbility Project

The AgrAbility Project assists agricultural and agribusiness workers who have physical and mental disabilities, including such disabilities as amputation, arthritis, spinal cord injury, and hearing impairments. Easter Seals and the University of Wisconsin administer a national program of education, outreach, and technical assistance to farmers with disabilities. State AgrAbility projects are a partnership between nonprofit disability service providers and the state U.S. Department of Agriculture (USDA) extension services. Staff from the state projects work with individual farmers and farm families to assess farm buildings and equipment to make recommendations on modifications that can help farmers with disabilities remain safely on the farm and help them find solutions to financing these modifications. To find out if your state has an AgrAbility program, call your local Easter Seals office or the National AgrAbility Project, toll-free, at 1-866-259-6280. See the Web site at http://www.agrabilityproject.org.

Area Agencies on Aging

Area Agencies on Aging (AAAs) provide many services to enable seniors to continue living independently in their homes, including information and referral, insurance counseling, and care management. By making a range of options available, AAAs make it possible for seniors to choose the services and living arrangement that suit them best. You can find your local AAA in the White Pages of your telephone directory or call the toll-free Eldercare Locator at 800/677-1116. This service is funded by the U.S. Administration on Aging and

administered in cooperation with the National Association of State Units on Aging. Individuals calling this service have access to over 4,800 state and local information and referral service providers, identified for every ZIP code in the country. The database also includes special purpose information and referral telephone numbers for Alzheimer's hotlines, adult day care and respite services, nursing home ombudsman assistance, consumer fraud, in-home care complaints, legal services, elder abuse/protective services, Medicare/Medicaid/Medigap information, tax assistance, and transportation.

National Association of Area Agencies on Aging
www.n4a.org

Eldercare Locator
www.eldercare.gov/eldercare/Public/Home.asp

Independent Living Centers

Independent Living Centers (ILCs) are typically nonresidential, private, nonprofit, consumer-controlled, community-based organizations providing services and advocacy by and for people with all types of disabilities. Their purpose is to assist individuals with disabilities to achieve their maximum potential within their families and communities. ILCs are also good sources of information and referral. A listing of ILCs by state is available online at www.ilru.org/html/publications/directory. You may also call their information line at 713/520-0232, ext. 130.

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