Cover page

Application for financial support

by

_____

(Family name, first name in printed letters)

_____

(Date of birth – DD.MM.YYYY)

to

Help! – Wir helfen! e.V.

Eichenweg 6

D- 74545 Michelfeld

Germany

1. Information concerning our organization and use of the forms

Who we are?

The organization „Help! - Wir helfen! e.V." is a non-profit organization based in Schwäbisch Hall (Germany). The organization helps in projects where individuals, especially children and young adults have so far in vain waited for urgent medical treatment (operations, medicine), but neither the state social security system nor their families can afford to cover the costs for the required treatment.
Our principle: To help people to help themselves!

Which preconditions and agreements are required?

The following documents have to be submitted

- Complete „Application for financial support" **with** traceable (medical) reports **and photos** of the patient **prior to** a medical treatment
- Medical reports **and photos** of the patient **after** the treatment
- Right to use the (medical) reports and photos arising from the medical treatment and its progress for advertising purposes of the organization „Help! - Wir helfen! e.V."

Our commitments of financial support are valid for 6 months. The written form is required.

How to use the application form?

The application contains the data of the patient (person concerned), his/her social and financial environment as well as the applied for financial support for the defined treatment. The application also comprises the medical data, the planned medical treatment and the indication of the hospital / doctor. The application form is part of our documentation principles towards the donors of our organization.

Concerning the diagnosis, please use chapters 7.1 to 7.3. As to the documentation of the result and the healing progress after the treatment, please use the appropriate annexes of the form.

Where to send the documents and photos?

Please send the documents (scans of the application form, photos, reports, etc.) via e-mail to:

report@help-wirhelfen.de

2. Application details

2.1 Details of the person concerned (patient)

Family name/given name(s): _____

Gender: ☐ female ☐ male ☐ divers nationality: _____

Date of birth (DD.MM.YYYY): _____ Country/place of birth: _____

Age: _____ Profession: _____ ___

Address: _____

E-Mail: _____ Phone: _____

2.2 In case of minors, details of parents or legal guardians

	Family name/given name(s)	Date of birth	Profession
Father:	_____	_____	_____
Mother:	_____	_____	_____

Phone-no. (Father/mother): _____

E-Mail: _____

2.3 Details of persons living in the same household (husband, siblings….)

Family name/given name(s)	Date of birth	School/Education/Occupation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2.4 Economic necessity: Monthly net income of all persons belonging to the household

2.4.1 Income per month

	person concerned	husband/ partner	parents	children	other persons
Wages/salary	_____ €	_____ €	_____ €	_____ €	_____ €
Pensions	_____ €	_____ €	_____ €	_____ €	_____ €
Social benefits	_____ €	_____ €	_____ €	_____ €	_____ €
Child benefits	_____ €	_____ €	_____ €	_____ €	_____ €
_____	_____ €	_____ €	_____ €	_____ €	_____ €
_____	_____ €	_____ €	_____ €	_____ €	_____ €
Subtotals	_____ €	_____ €	_____ €	_____ €	_____ €

Total amount _____ **€**

2.4.2 Extraordinary (medical) expenses per year …

for _____ _____ €

for _____ _____ €

3. Costs and financing of the treatment as well as application for coverage of the costs

3.1 Total amount of the treatment _____ €

thereof _____ € for _____

thereof _____ € for _____

thereof _____ € for _____

see quotation of medical costs dated (DD.MM.YYYY) _____

3.2 Partial financing by a health insurance or similar _____ €

☐ No ☐ Yes by (name, phone):

_____

_____

3.3 Partial financing by other organizations, family, friends _____ €

☐ No ☐ Yes by (name, phone):

_____

_____

3.4 Application for coverage of the costs
It is herewith applied for coverage of the costs by "Help! – Wir helfen! e.V." amounting to _____ €

4. Contact details of the hospital/practice/doctor

(1) Hospital in case of in-patient treatment (name, country/place/phone/E-Mail):

_____

_____

(2) Attending doctors for out-patient treatment (name, country/place/phone/E-Mail):

_____

_____

5. Declaration of financing the medical treatment

I hereby declare that the requested amount of financial support is not exceeding the total costs of the treatment. The estimated medical costs are enclosed. I assure that the indicated information is correct and given to my best knowledge and belief.

Date: _____ _____

(Signature of the patient or in case of minors of the parents or legal guardian)

6. Consent and declaration to the release of documents and photos

I,

_____

(patient's name or name of parents or legal guardian in case of minors)

hereby give „Help! – Wir helfen! e.V." the absolute and irrevocable right and permission, with respect to the photos, radiographs and patient's details etc. taken or given of me / respectively the patient by Help! – Wir helfen! e.V. respectively herewith entrusted persons (hospital employees/doctors etc.) or which I have handed over to them, to use them as follows:

a) To copyright the same under its own name or any other name it may choose.

b) To reuse the same in whole or in any part, individually or in connection with other photos in any medium (printed media, in the web etc.) for illustration, promotion/advertising and publication purposes of information, however, without being limited to it. I agree that my name is used in publications of all kinds.

c) To hand over the photos taken by me and the personal details for review to third parties – also electronically – and to memorize them electronically.
I hereby waive and discharge Help! – Wir helfen! e.V. and the persons having taken the photos and generated the report and using them in the name of Help! – Wir helfen! for association purposes from any and all claims and demands arising thereof. I shall release the photos and reports for the use of Help! – Wir helfen! e.V. This also applies for photos and reports having been taken and generated by other institutions (doctors/hospitals etc.), as for example radiographs and/or ultrasonic images etc.
I have read and completely understood the contents of this declaration.

_____

(Place and date)

_____ _____

(Name in printed letters) (Signature of the patient or legal guardian in case of minors)

7.1 Evaluation questionnaire for jaw-lip-palate-cleft - status before treatment

1. Summary of medical anamnesis including previous diseases

2. Diagnosis/es

3. Planned treatment /Aimed result

4. Present health status/laboratory status

5. Additions/informative photo documentation before the operation have to be enclosed

7.2 Evaluation questionnaire for ophthalmic diseases (e.g. Cataract*) – status before treatment

1. Diagnosis/es

_____

2. Planned treatment (please tick)

☐ **Right eye** ☐ **Left eye**

3. Eye diagnostics with informative photo documentation

	Right eye	**Left eye**
Best corrected visual acuity		
Refraction		
Ocular pressure		
Slit lamp findings		
Fundus findings		

4. Additions as far as they are relevant for the ophthalmic disease (summary of the medical anamnesis respectively previous diseases)

_____

_____

_____

* Precondition for financing a Cataract operation:

- Best corrected binocular visual acuity shall be under 0,3 (according to the definition of visual impairment of WHO level 1), slitlamp-photos before and after surgery which show pre-op the cataract and post-op the implanted intraocular lens

7.3 Evaluation questionnaire for general / accident surgical / orthopedic treatment - status before the treatment

1. Summary of the medical anamnesis

_____

_____

_____

2. Diagnosis/es

_____

_____

3. Planned treatment / Aimed result

_____

_____

4. Physical check-up results

- Ability to walk – with or without walking aids

  _____

- Walking distance in meters (m)

  _____

- Pain Situation:
  - at rest: regular taking of painkillers over 24 hours

    _____

  - in movement / walking : painkillers are regularly necessary

    _____

- Functional deficits in the performance of everyday life, which?
  - active joint mobility of the corresponding joints according to the neutral-0-method (extension(E)-flexion(-F), e.g. knee joint 10-0-90 degrees:

    _____

    _____

- passive mobility: E-F

  _____

- stability of the joint

  _____

5. Laboratory status

- Hb value
- Blood cell counting
- …

6. Radiographs in 2 levels

- Scan (X-Ray)
- Image file (jpeg-file)

7. Photos of the patient

8. Remarks

_____

_____

_____

Annexe 1

Status after the treatment of jaw-lip-palate-cleft

1. The treatment was successfully completed

☐ yes ☐ no

2. The treatment has to be continued. A further operation is necessary. Another application will be submitted

☐ yes ☐ no

3. Informative picture after the operation with healed wound has to be enclosed, namely

- in case of lip-cleft: preferably with a smiling face
- in case of palatal cleft: whole head with visible jaw/palate

Annexe 2

Status after the treatment of an ophthalmic disease (e.g. Cataract)

1. The treatment was successfully completed.

☐ yes ☐ no

2. The treatment has to be continued. A further operation is necessary. A new application will be submitted.

☐ yes ☐ no

3. Photo documentation has to be enclosed, namely

- photo of the patient's face
- informative photo of the operation result (eye)

Annexe 3a

Status after the treatment (10 to 14 days) in case of general / accident surgical / orthopedic treatment

1. Report especially concerning the course of the treatment / unwanted incidents / complications:

_____

_____

_____

2. Executed treatment:

_____

_____

3. Rehabilitation necessary: ☐ yes ☐ no

_____

4. Discharge from hospital: after _____ days

_____

5. Out-patient follow-up treatment required: ☐ yes ☐ no

If yes: which kind? _____

Orthosis / bandage required? ☐ yes ☐ no

6. Operation wound healed: ☐ yes ☐ no

_____

7. Symptoms of inflammation: ☐ yes ☐ no

8. Postoperative radiographs (Scan-images) ☐ are enclosed

9. Remarks

_____

_____

Annexe 3b

Status after the treatment (6 to 8 weeks) for general / accident surgical / orthopedic treatment

1. Date of the last progress control:

_____

2. Medical conditions of the patient:

_____

_____

3. Symptoms of inflammation: ☐ yes ☐ no

4. Functional status:

- Measuring of active joint mobility according to the neutral-0-method (extension(E)-flexion(F)), e.g. knee joint 10-0-90 degrees

  _____

  _____

- Passive joint mobility (E- F):

  _____

  _____

- Joint stability: _____
- Symptoms of muscular atrophy of affected extremities: yes no
- Symptoms of swelling: ☐ yes ☐ no
- Wound normally healed: ☐ yes ☐ no
- Walking distance in meters without walking aids: _____
- Walking aids required: ☐ yes ☐ no

5. Photo documentation of the patient: ☐ is enclosed

6. Radiographs in 2 levels:

- Scan 6 weeks after operation ☐ is enclosed

7. Further treatment necessary: ☐ yes ☐ no

If yes, of which kind? _____

_____

8. Remarks:

_____

_____