# San Antonio Amputee Foundation Application for Services

Please complete the form below to apply for assistance.

**Full Name** *

First Name Middle Name Last Name

**Date of Birth** *

Month Day Year

**Current Address**

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

**Email Address** *

example@example.com

**Cell Phone Number** *

Area Code Phone Number

**Can you receive text messages at this number?** *

- ◯ Yes
- ◯ No

**Do you have health insurance?** *

- ◯ Yes
- ◯ No

**Type of services requested** *

**Level of Amputation (check all that apply)** *

- ☐ Lower left leg
- ☐ Lower right leg
- ☐ Upper left leg
- ☐ Upper right leg
- ☐ Below left elbow
- ☐ Below right elbow
- ☐ Above left elbow
- ☐ Above right elbow
- ☐

**Year of Amputation (if multiple dates, choose most recent date)** *

Month Day Year

**Reason for Amputation** *

**Are you currently in the hospital?** *

- ◯ Yes
- ◯ No

**If YES, which hospital?**

**Additional Comments?**

Submit

Submit by mailing to SAAF Application, P. O. Box 591131, San Antonio, TX 78259