Operation Walk USA 2019 Prospective Patient Registration

WELCOME!

Thank you for your interest in Operation Walk USA. We are currently collecting **prospective** patients' information **in consideration** for pro bono hip and knee replacement surgeries to take place **December 2-7, 2019**. We understand that you, or someone you know, may be in need of a free total hip or total knee joint replacement. Our mission is to assist individuals like you. Please note, we offer only hip and knee replacement surgeries to adult (18+ y.o.) patients; at this time we do not offer any other surgical procedures.

To be considered, prospective patients must be:
- US citizens or **legal permanent residents;**
- Uninsured, and
- At or below the 300% federal poverty guidelines.

For safety and liability reasons, we do not encourage or enable prospective patient travel to a hospital located at a distance greater than approx. a 1-2 hour car ride away from home town.

Medicare/Medicaid patients, or patients with any insurance coverage, are not eligible to receive assistance through Operation Walk USA.

Completion of this form **DOES NOT** indicate a patient's acceptance into the program. Acceptance is subject to hospital availability, clinical and financial screening, and meeting patient qualification criteria.

PLEASE READ THIS IMPORTANT STATEMENT IN ITS ENTIRETY

This is NOT a secure site. You are submitting this information voluntarily because you are a prospective patient interested in being considered for Operation Walk USA, or you have permission to submit this information on behalf of a prospective patient.

Operation Walk USA and its affiliates (volunteer medical professionals, participating hospitals, agencies, etc.) respect your privacy. Operation Walk USA collects, exports, and uses personal information to manage your relationship with Operation Walk USA and its affiliates.

By using this registration site, you voluntarily AGREE to share with Operation Walk USA personal information as identified in this form.

Operation Walk USA may keep and use personal information we collect from you through this registration form to provide you with access to our participating health care providers. In addition, we may use your information for the purposes, including but not limited to, the following:

- To respond to your requests;
- To develop records, including records of your personal information;
- To contact you with information that might be of interest to you;
- For analytical purposes and to research, develop and improve programs, services and content;
- To protect our rights or property;
- To protect someone else's health, safety or welfare;
- To comply with a law or regulation, court order or other legal process.

Operation Walk USA will not share your personal information collected through this registration form with an unrelated third-party without your permission, except as otherwise provided in this Authorization Statement.

In ordinary course of business, Operation Walk USA will share some personal information with entities that we engage to perform services or functions on our behalf. In all cases in which we share your personal information with a third-party, we will not authorize them to keep, disclose or use your information with others except for the purpose of providing the services we asked them to provide. We will not sell, exchange or publish your personal information under any circumstances.

Operation Walk USA may be legally compelled to release your personal information in response to a court order, subpoena, search warrant, law or regulation.

* 1. **AGREEMENT**

By checking the box below, I certify that I am a prospective patient, or am authorized by a prospective patient, to complete this form. I have provided accurate and true information to the best of my understanding and belief. I understand that to be considered I will be asked to provide additional information and documentation to support my application, and I am willing and able to do so.

I have read and agree with the statement above. (You must check this box in order to proceed.)

☐ Agree

* 2. **PROSPECTIVE PATIENT'S CONTACT INFORMATION:**

First Name:

Last Name:

City:

State:

Zip Code:

Primary Phone Number:

Email Address:

Nearest/Alternative Major City (within 70 miles from home):

* 3. **PROSPECTIVE PATIENT'S BIOLOGICAL SEX:**

- ◯ Male
- ◯ Female

* 4. **PROSPECTIVE PATIENT'S VERIFIABLE CITIZENSHIP/RESIDENCY STATUS:**

- ◯ US Citizen
- ◯ Permanent US Resident (Green Card holder)

* 5. **PROSPECTIVE PATIENT'S DATE OF BIRTH:**

MM/DD/YYYY:

* 6. **HAS THE PATIENT BEEN TREATED THROUGH OPERATION WALK USA PREVIOUSLY?**

- ◯ YES
- ◯ NO

7. If answered "YES" above, please indicate:

Year of surgery:

Type of surgery:

Hospital:

City and state of hospital:

Name of surgeon:

* 8. **PROSPECTIVE PATIENT'S EMPLOYMENT STATUS:**

- [ ] Self-employed
- [ ] Employed full-time
- [ ] Employed part-time
- [ ] Unemployed
- [ ] Retired
- [ ] Other (please specify)

9. **PROSPECTIVE PATIENT'S INSURANCE COVERAGE STATUS:**

- [ ] Uninsured
- [ ] Insured, but insurance will not cover total joint replacement
- [ ] Insured, but cannot afford co-pay for total joint replacement
- [ ] Medicare
- [ ] Other (please specify)
- [ ] Medicaid
- [ ] Applying for Medicare/Medicaid
- [ ] Applying for coverage on Healthcare.gov

10. If applying for Medicare/Medicaid or coverage on Healthcare.gov (a.k.a., Affordable Care Act, a.k.a., Obamacare), when is coverage expected to begin (MM/YYYY)?

* 11. Will the patient be able and willing to submit the required documentation verifying citizenship, employment, income, insurance status?

- ( ) Yes
- ( ) No

Comments:

* 12. **PROSPECTIVE PATIENT'S MEDICAL CONDITION: Patient might be in need of:**

- [ ] RIGHT total HIP (primary) replacement
- [ ] LEFT total HIP (primary) replacement
- [ ] RIGHT total KNEE (primary) replacement
- [ ] LEFT total KNEE (primary) replacement

If this is a revision procedure (of a surgery previously done), please describe below by indicating right or left REVISION hip or knee:

* 13. How has this condition been established?

- [ ] By primary care physician
- [ ] By an orthopaedic surgeon
- [ ] Other (please specify)

* 14. Does the patient have access to reliable and regular means of transportation?

- ( ) Yes
- ( ) No

* 15. The patient...

- [ ] Lives alone
- [ ] Lives with a family member(s), i.e., shares the same home
- [ ] Has close family / friends near by

16. OPTIONAL: Briefly describe patient's condition or provide any additional relevant information:

17. OPTIONAL: Additional contact information

Full name:	
Relationship to prospective patient:	
Best phone number:	
Email address:	

18. OPTIONAL: How did you hear about Operation Walk USA?

- [ ] Word of mouth/friends/relatives
- [ ] Searched online/Google/Bing/other engine
- [ ] Hospital/primary care physician
- [ ] Social media/Facebook/Twitter
- [ ] News and media/newspaper/TV/radio
- [ ] Other (please specify)

THANK YOU FOR COMPLETING THIS REGISTRATION FORM

Please click on the **SUBMIT** button below to successfully enter your information. **You WILL NOT receive a confirmation that your information has been submitted**. You may email us at opwalkusa@aaos.org to verify your submission. Allow 7-10 business days for a response. **Please DO NOT email any additional information. Any additional information or documents you might need to submit will be requested from you separately.**

Planning the annual Operation Walk USA takes many months. You may not hear from us and/or from a participating hospital until sometime in September-October 2019.

Please understand that out resources are limited, and we are not always able to return your calls or reply to individual emails.

Thank you for your patience and understanding.

Sincerely,

Operation Walk USA Team

Updates are posted on:
www.operationwalkusa.org
Follow us on FACEBOOK and TWITTER

PLEASE REMEMBER TO CLICK ON THE "SUBMIT" BUTTON BELOW.