



WORLD CRANIOFACIAL FOUNDATION
Medical City Dallas • 7777 Forest Lane • Suite C-621 • Dallas, Texas 75230
Mailing Address: P.O. Box 515838 • Dallas, Texas 75251-5838
Telephone (972) 566-6669 Fax (972) 566-3850 1-800-533-3315

APPLICATION FOR ASSISTANCE (ADULTS)

The mission of the World Craniofacial foundation is to give help, hope and healing to people with craniofacial abnormalities and their families. In certain cases, we award financial aid grants to families to assist with secondary costs of craniofacial care. Our grants may be used toward food, travel and lodging expenses associated with doctors' appointments, surgeries and rehab. We provide help for the child receiving treatment and one parent or legal guardian.

If you believe you may qualify for a grant from the World Craniofacial Foundation, please fill out application completely, sign the photo release and consent release at the end of the application (last 2 pages of application) and include the following items:

1. A recent photograph of the patient (will not be returned).
2. A copy of any medical records/information on the patient.
3. A letter from attending physician, confirming appointment date, treatment plan and estimated length of stay.
4. A copy of your most recent IRS tax return.
5. A copy of your most recent check stub.
6. Send your application to:

**World Craniofacial Foundation
P.O. Box 515838
Dallas, Texas 75251-5838**

To learn more about our foundation, please visit
www.worldcf.org.

APPLICATION FOR ASSISTANCE - ADULTS

Name of patient: _____

Date of Application: ___/___/_____

Application is for assistance with (mark all that apply):

- transportation food lodging

Age _____ Date of birth ___/___/___ Male or Female: _____

Patient's Social Security number _____-_____-_____

Street address: _____

City _____ State _____ Zip _____

Home phone: (____) _____ Mobile phone: (____) _____

Email Address: _____

Patient's diagnosis: _____

Patient's physician name: _____

Physician street Address: _____

City _____ State _____ Zip _____

Physician Contact # _____

Total number of persons in household: _____

Names and ages of all children in household:

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current medical/surgical insurance includes:

- Medicaid Other _____ None

- Group insurance through employer

Name of insurance _____

If group insurance, name of group employer _____

EMPLOYMENT

Occupation: _____ Employer: _____

Employer's address: _____

City _____ State _____ Zip _____

Phone _____

Spouse's Occupation: _____ Spouse's employer: _____

Spouse's employer's address: _____

City _____ State _____ Zip _____

Phone _____

Employer of other family member in household if 18 years old:

Name of other family member _____

Occupation _____

Name of Employer _____

Employer's Address _____

City _____ State _____ Zip _____

MONTHLY INCOME

Salary \$ _____

Salary/wages/tips of other family members \$ _____

Other income (please itemize) \$ _____

Total Monthly Income \$ _____

MONTHLY EXPENSES

Home mortgage (or rent) \$ _____

Automobile payment(s) \$ _____

\$ _____

Utilities (electric, gas, water) \$ _____

Telephone \$ _____

Insurance:

• automobile \$ _____

• life \$ _____

• medical \$ _____

• property \$ _____

Medical expenses \$ _____

\$ _____

\$ _____

Child care \$ _____

Banks, finance companies \$ _____

Charge accounts, credit cards \$ _____

Other \$ _____

Total Monthly Expenses \$ _____

ASSETS

(List total value of each, answer NONE if applicable)

Cash in bank(s) or other institutions

Name of bank _____

Account No. _____

\$ _____

U.S. Savings Bonds \$ _____

Life Insurance (cash value) \$ _____

Stock Securities \$ _____

Real estate (home) \$ _____

Real estate (other properties) \$ _____

Automobile(s) \$ _____

_____ \$ _____

_____ \$ _____

Other assets \$ _____

_____ \$ _____

Total Assets \$ _____

LIABILITIES

(List total amount due on each)

Notes payable:

Bank _____ \$ _____

Finance company _____ \$ _____

Automobile(s):

Auto 1 Make/Model: _____ \$ _____

Auto 2 Make/Model: _____ \$ _____

Other _____ \$ _____

Accounts payable:

Credit cards: \$ _____

Charge accounts \$ _____

Other \$ _____

Mortgage payable (balance due on home) \$ _____

Mortgage payable (other properties) \$ _____

Total Liabilities \$ _____

The above statement of Assets and Liabilities is as of the ___ day of _____, 20___, and is for the exclusive use of the World Craniofacial Foundation in assessing this request for financial assistance. I hereby authorize the World Craniofacial Foundation to disclose and use the information as necessary.

Signed: _____

Date: _____

Please describe your request – estimate any future expenses for which you are seeking assistance.

Use the space below to explain any unusual circumstances you would like this Foundation to know in assessing your request for financial assistance.

Have you applied for assistance with any other organization? No Yes

If yes, please provide the following:

Name of organization: _____

Organization phone: (_____) _____

The undersigned certifies that the information contained in this Application for Assistance is true and current.

Signed: _____ **Date:** _____



PHOTO RELEASE FORM

Dated: _____

I, _____ (beneficiary's name) hereby give the World Craniofacial Foundation the absolute and irrevocable right and permission, with respect to the photographs taken of me by World Craniofacial Foundation employees, Medical City Dallas employees or photographs I have turned over to them and are in their possession:

- A) To copyright the same under its own name or any other name it may choose.
- B) To use, re-use, publish and/or re-publish the same in whole or in any part, individually or in conjunction with other photographs, in any medium and for any purpose whatsoever, including (but not by limitation) illustration, promotion and/or advertising and/or trade; and
- C) To use my name in connection therewith if they so choose.

I hereby release and discharge the World Craniofacial Foundation from any and all claims and demands arising out of or in connection with the use of the photographs, including any and all claims for libel.

This authorization and release shall also ensure to the benefit of the legal representatives, licensees and assigns of the World Craniofacial Foundation as well as the person(s) or entity(ies) for whom it took the photographs.

I have read the foregoing and fully understand the contents thereof.

(Witness signature)

(Beneficiary signature or guardian if minor)

(Legal relationship to beneficiary)

(Beneficiary address)



WCF CONSENT FOR RELEASE OF INFORMATION

1. I hereby authorize World Craniofacial Foundation
Address: 7777 Forest Lane C621 Dallas TX 75230
Phone: 972-566-6669 Fax 972-566-3850

To release the following information from the health records of:

Patient's name: _____

Date of Birth: _____ SS# _____

Covering the period(s) of treatment from _____ to _____

2. Information to be released:

_____ History & Physical _____ Complete health record

_____ Billing records

_____ Operative Reports _____ Other _____

3. Information is to be released from (fill in your physician's info):

Name: _____

Address: _____

City: _____ State: _____ Zip _____

4. Purpose of Disclosure: _____

5. I understand this consent can be revoked at any time except to the extent that disclosure of information has already occurred prior to receipt of the revocation by this office. If revocation is not received, authorization will be considered valid for a period of time not to exceed one year.

6. Date this consent expires: _____

7. The facility, its employees and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

8. I understand that the information released could contain reference to or results of HIV antibody (AIDS) testing.

SIGNATURE: _____ **DATE:** _____

Relation to Patient: _____