WORLD CRANIOFACIAL FOUNDATION
Medical City Dallas • 7777 Forest Lane • Suite C-616 • Dallas, Texas 75230
Telephone (972) 566-6669 Fax (972) 566-3850 1-800-533-3315

APPLICATION FOR ASSISTANCE (CHILDREN)

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 doctor 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. Photograph 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 (if subject to US taxes).**
5. **A copy of your most recent check stub.**
6. **Send your application to:**

World Craniofacial Foundation
7777 Forest Lane, Suite C-616
Dallas, Texas 75230
USA

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

GENERAL INFORMATION

Date of Application _____/_____/_______

Application is for assistance with: ☐ transportation ☐ food ☐ lodging

Name of patient ____

Age_____ Date of birth ____/____/______ Male or Female: _______

Name of parents/guardians: ____

Street address: ____

City: ___________________________ State/Provence/Area: ____________________________

Zip/Postal Code: _______________ Country: _______________________________

Phone (home) (_____)_________________ Phone (mobile): (_____)__________________

Email address where we may contact you ____

Referred to WCF by ____

Street address ____

Patient's diagnosis____

Patient's physician name ____

Physician Street address: ____

City: ___________________________ State/Provence/Area: ____________________________

Zip/Postal Code: _______________ Country: _______________________________

Physician Phone (_____)______________________

Total number of persons in household ___________

Names and ages of all children in household

Name	Age	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

Father's occupation ____________________ Father's employer _____________________

Father's employer's address ____

City: _________________________ State/Provence/Area: _________________________

Zip/Postal Code: ______________ Country: _____________________________

Phone (____)_____________

Mother's Occupation_______________________ Mother's employer___________________

Mother's Employer's Address ____

City: _________________________ State/Provence/Area: _________________________

Zip/Postal Code: ______________ Country: _____________________________

Phone (____)____________

MONTHLY INCOME

Salary/wages/tips of father	$______________________
Salary/wages/tips of mother	$______________________
Salary/wages/tips of other family members	$______________________
Other income (please itemize)	$______________________
____	$______________________
Total Monthly Income	$______________________

MONTHLY EXPENSES

Home mortgage (or rent)	$______________________
Automobile payment(s)	
Auto 1 Make/Model _________________	$______________________
Auto 2 Make/Model _________________	$______________________
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 – list None or NA if necessary)

Cash in bank(s) or other institutions $____________________________
Name of bank _________________________________
Account No. __________________________________

Name of bank _________________________________
Account No. __________________________________ $____________________________

U.S. Savings Bonds (If any) $____________________________
Life Insurance (cash value) $____________________________
Stock Securities $____________________________
Other $____________________________
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) _______________________________ $____________________________
____ $____________________________
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:** __________________

REQUEST FOR ASSISTANCE

Please describe your request. Please estimate any future expenses for which you are seeking assistance including mileage, airfare, daily food expenses, and lodging expenses.

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

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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 legal 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 C616 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# (If applicable)_______________

   Covering the period(s) of treatment from _______________ to ________________

2. Information to be released:

   ______ History & Physical
   _______Billing records
   ______ Other _____________________________
   ______ Complete health record
   ______ Operative Reports

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

   Name: ____
   Address:____
   City: _________________________ State/Provence/Area: _________________________
   Zip/Postal Code _________________ Country: ___________________________________

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) or COVID-19 testing.

SIGNATURE: ____________________________________ **DATE**: _______________________

Relation to Patient: _________________________________