Fresh Start
Caring For Kids Foundation
Co-founded by The Plastic Surgery Foundation and Fresh Start Surgical Gifts

For Office Use Only

Date Received:
Received By:

APPLICATION FOR MEDICAL SERVICES

Name of Applicant: _____

Address: _____
Street Apt. No.

_____
City State Zip Country

County of Residence (U.S. Patients only) _____ Email Address:_____

Daytime Telephone: (____) _____ **Evening Telephone:** (____) _____

Date of Birth (Day/Month/Year): ____/____/____ **Age:_____*** **Sex:** M ____ F ____

***If you are 18 years old or older, you must also submit a letter with your application that explains your situation and how getting services from Fresh Start would give you a fresh start in life.**

Citizenship of prospective patient? _____ Language patient/ patient's parents speak?_____

If not in the US, do the patient and one parent have Passports?_____ Visas?_____ Need Transportation ?_____

_____

Briefly describe type of surgery or treatment needed and why: _____

_____

Is the problem: a) Related to a congenital birth defect b) Related to an accident or trauma c) Caused by physical abuse
d) Caused by violent act (police report needed if over age 21)

Other health problems? _____ Any Allergies? _____

List any medications currently taking: _____

Name of Parent/Guardian: _____

Address of Parent/Guardian: _____
Street Apt. No.

_____
City State Zip Country

Daytime Telephone: (____) _____ **Evening Telephone:** (____) _____

Date of Birth (Day/Month/Year): ____/____/____ **Sex:** M ____ F ____

Name of Physician: _____ **Telephone:** (____) _____

Has the prospective patient ever received any treatment for the problem?
Yes _____ (Contact person needs to obtain copies of all medical records and current front and side-view photographs.
The records and photographs should be forwarded with application.) **No _____**

Does the patient have medical insurance coverage?
Yes _____Specify type: State subsidized program_____ **No _____**
Private_____
Other_____

If yes, please attach a copy of both sides of the insurance identification card and policy listing those services not covered.

Fresh Start
Caring For Kids Foundation
Co-founded by The Plastic Surgery Foundation and Fresh Start Surgical Gifts

List Patient & Family Members	Income Source/ Type of Employment	Age	Relation to Patient	Gross Yearly Income	Check if Person is a Dependent
Include SSI, SSD, SS, IHSS, Alimony, Child Support, Pension, Retirement, and other types of regular assistance.					
			Total Household Gross Annual Income:		

If a U.S. citizen, please attach a copy of the most current filed IRS tax return.

Please Mark One:

_____ Rent **Monthly Rent** **$_____**

_____ Own Home **Monthly Mortgage Payment** **$_____**

Assets (What You Own)	Amount $	Liabilities (What You Owe)	Amount $
House		Mortgage	
Savings		Loans	
Stocks/Bonds/Investments		Credit Cards	
Other		Other	
Total Assets		Total Liabilities	

How did you learn about Fresh Start Caring For Kids Foundation? _____

Please return completed application along with current front and side view photographs to the address above. Photographs become the property of Fresh Start Caring For Kids Foundation and cannot be returned. Applications without photographs cannot be processed. Please call (844) 374-5437 for more information.

I declare under the penalty of perjury that the foregoing is a true and accurate statement as to the availability of any insurance or state funded reimbursements for the surgery requested of Fresh Start Caring For Kids Foundation.

Signature: _____ **Date (Day/Month/Year):** ____/____/____
Legal Guardian if applicant is a minor

Printed Name: _____ **Send Application?____ Date:_____**