Angel Fingers Foundation, Inc. Application for Financial Assistance

PO Box 871883 ♦ New Orleans, LA 70187 ♦ (504) 267-5449

PURPPOSE:

Angel Fingers Foundation will provide financial assistance to the legal guardians (not exceeding two) of children up to and including age twelve with syndactyly who will have corrective surgery. The mission of Angel Fingers Foundation is to work diligently to improve the quality of life of children afflicted with syndactyly by ensuring that they are able to live productive lives and participate in all life experiences. It is our hope to eradicate syndactyly through research, education and advocacy.

I. PERSONAL INFORMATION

Legal Guardian's Name: ____

First Middle Last

Social Security Number: __________________________ Date of Birth: ___________________

Address: _______________________ E-mail Address: _______________________

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Home Phone: _(___)_____________

Mobile Phone: _(___)_____________

Work Phone: _(___)______________

Patient's Name: ____

First Middle Last

Social Security Number: ___________________________

Date of Birth:____________________ Age: _____________

Address: _______________________

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Height: ___________ Weight: ____________

II. MEDICAL INFORMATION

Primary Care Physician: ____

Physician's Address: ___________________________ Phone Number: ________________

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Length of time under physician's care: ________________

Medical Insurance: _______________________

Does patient have any pre-existing conditions? ____

Current medications: ____

Allergies: ____

Medical history/past surgeries:

Does patient need special accommodations? ____

Attach a photo or drawing of affected area

III. EMERGENCY CONTACT INFORMATION

Please list someone other than the legal guardian.

Name: ____

Address: __________________________ Primary Phone: (___)___________________

__________________________ Secondary Phone: (__)__________________

___________________________ E-mail Address: ________________________

Relationship to Patient: ____

How long has patient known this person: ____

III. CERTIFICATION

I certify that the information I've provided is true and I further certify that I am authorized to act on behalf of the patient.

Printed Name: ________________________________ Relationship: _________________

Signature: ____ Date: _________________

Signature: ____ Date: _________________

MAIL COMPLETED APPLICATION WITH SIGNATURE TO

Angel Fingers Foundation, Inc.

PO Box 871883

New Orleans, LA 70187

Contact the financial assistance coordinator at (504) 267-5449 with any questions you may have.

Note: For international applicants, please ensure that all vaccinations/immunizations and passport are current.