APPLICATION FOR MEDICAL AID

Applicant's Name: ____

Applicant's Social Security Number: __________________________________

Address: ____

____

Phone: ____

THE B.F. AND ROSE H. PERKINS FOUNDATION

45 E. Loucks Street, Suite 110

P.O. Box 1064

Sheridan, WY 82801

Office: (307)674-8871

Fax: (307)674-8803

APPLICATION FOR MEDICAL AID

RULES AND REGULATIONS:

1. Applicant must have resided in Sheridan County, Wyoming for at least 1 year and be over the age of 1 year and under the age 21 years.
2. All applications must have prior board approval before any funds will be advanced.
3. Applicant must show financial need.
4. Grants are subject to the Foundation's Will and bylaws and rules and regulations adopted by the Board of Directors.

IS INSURANCE AVAILABLE? YES ☐ NO ☐

Name of Insurance Company and Policy Number or Group Number: ________________________________
____

Estimated amount of insurance payment for this request: $____________________________________

List other organizations and/or agencies where applications for funds have been or will be submitted:

____
____
____

IF THIS APPLICATION FOR MEDICAL AID IS GRANTED, I AGREE TO ABIDE BY THE RULES AND REGULATIONS STATED ABOVE.

DATED: _____________________________________ ____

(SIGNATURE OF APPLICANT IN FULL)

____ ____

(PARENT'S ADDRESS) (SIGNATURE OF PARENT/GUARDIAN)

____ ____

(PARENT'S ADDRESS) (SIGNATURE OF PARENT/GUARDIAN)

IN ORDER TO QUALIFY FOR FINANCIAL ASSISTANCE, APPLICANT AND PARENTS OR GUARDIANS MUST HAVE COMPLETED AND SIGNED THE APPLICATION FORM AND SUBMITTED A COPY OF THEIR MOST RECENT FEDERAL TAX RETURN. IF APPLICANT, PARENT OR GUARDIAN HAS NOT FILED A FEDERAL TAX RETURN, PLEASE STATE SO.

Applicant remains free to select health care providers of their choice. The Foundation may consider comparative costs of various providers in determining which applications to approve and amounts to be granted. The Foundation may request a second opinion from another health care provider to help determine need and cost.

B.F and ROSE H. PERKINS FOUNDATION ~ SHERIDAN, WYOMING

APPLICATION FOR MEDICAL AID

(No payment will be made without prior board approval.)

Name of Child: ____

Current Age: ____________ **Sex:** ____________ **Date of Birth:** ______________________________

Number of years child has lived in Sheridan County: ______________________________

Fathers (Guardian) Name: ______________________________

Address: ______________________________

Social Security Number: ______________________________

Married ☐ **Divorced** ☐ **Deceased** ☐**

****If yes, is child support being received?**
$______________________________

Number of Dependents living at home: ______________________________

Ages: ______________________________

Number of years living in Sheridan County: ______________________________

Do you Own your home ☐ **or Rent** ☐

Employer: ______________________________

Address: ______________________________

Phone: ______________________________

Occupation: ______________________________

Number of years at present job: ______________________________

Previous Employer if less than 2 years on present:

Previous Employer: ______________________________

Occupation: ______________________________

Income: ______________________________

Other Income: ______________________________

Total Amount of all Assets Owned: $______________________________

____

Total Amount of All Liabilities: $______________________________

____

____

Signature

Date:______________________________

Mothers (Guardian) Name: ______________________________

Address: ______________________________

Social Security Number: ______________________________

Married ☐ **Divorced** ☐ **Deceased** ☐**

****If yes, is child support being received?**
$______________________________

Number of Dependents living at home: ______________________________

Ages: ______________________________

Number of years living in Sheridan County: ______________________________

Do you Own your home ☐ **or Rent** ☐

Employer: ______________________________

Address: ______________________________

Phone: ______________________________

Occupation: ______________________________

Number of years at present job: ______________________________

Previous Employer if less than 2 years on present:

Previous Employer: ______________________________

Occupation: ______________________________

Income: ______________________________

Other Income: ______________________________

Total Amount of all Assets Owned: $______________________________

____

Total Amount of All Liabilities: $______________________________

____

____

Signature

Date:______________________________

APPLICATION FOR MEDICAL AID

B.F. AND ROSE H. PERKINS FOUNDATION

Medical - Dental Form

Was this patient referred to you by their Orthodontist? Yes ☐ No ☐

Patient's Name: ____

Sex: _________ Age: _______

Nature of illness, disease or defect for which grant is requested:

____
____
____
____
____
____
____
____
____

Estimated time and total cost of treatment: _______________________________________ $___________________

I, ________________________________ agree to the release of my health information to B.F. and Rose H. Perkins Foundation and to the Foundations referring specialist for review as to the specific reason for this request. I understand this may include my health history, radiographs and other test results deemed to impact my overall health by the delivery of these orthodontic services.

____ Date: _______________________

(SIGNATURE OF APPLICANT OR SIGNATURE OF PARENT/GUARDIAN (OF MINOR)

I believe the Patient can be improved sufficiently to warrant the medical treatment recommended by me.

Doctor or Dentist Signature: ____

Date:_______________________

Doctor or Dentist Name: ____

Address:____

Phone: ( ) ____________________ Email: ______________________________________

APPLICATION FOR MEDICAL AID

B.F. AND ROSE H. PERKINS FOUNDATION

Orthodontia Form

Has this patient been reviewed recently by a dentist for decay, periodontal disease or extractions? Yes ☐ No ☐

(If no, the Dental Form has to be filled out by the Dentist before continuing)

Patient's Name:____ Sex: ____________ Age: _________

Primary Dentist's Name: ____________________________________ Date of last visit to Dentist: _____________________

Does the Patient have malocclusion associated with:

Cleft lip/cleft palate? Yes ☐ No ☐ Crainofacial Syndrome? Yes ☐ No ☐

Nature of illness, disease or defect for which grant is requested:

____

____

____

With Patient in centric position record the following (in mm)

Overbite: ____________ Overjet: ____________ Mandibular protrusion: ____________ Anterior open bite: ____________

Designate impacted teeth by # ____

Estimate intra-arch crowding maxilla: __________________ mandible: ___________________

Designate teeth in anterior cross-bite: ____

Designate teeth in posterior cross-bite: ____

Noted intraoral and/or extra-oral habits: ____

Designate teeth involved in palatal impingement: ____

Will this Patient require maxilla-facial surgery to complete orthodontic treatment? Yes ☐ No ☐

Please describe in detail why work is necessary:

____

____

____

Provide copies of 3 intra-oral and 3 extra-oral photographs and a duplicated panoramic radiograph. Include any additional photographs to clarify a unique condition. (These can be returned to the Orthodontist on request)

Estimated time and total cost of treatment: ____ $___________________________

I, ____ agree to the release of my health information to B.F. and Rose H. Perkins Foundation and to the Foundations referring specialist for review as to the specific reason for this request. I understand this may include my health history, radiographs and other test results deemed to impact my overall health by the delivery of these orthodontic services.

____ Date: ______________________________

(SIGNATURE OF APPLICANT OR SIGNATURE OF PARENT/GUARDIAN (OF MINOR)

I believe the Patient can be improved sufficiently to warrant the medical treatment recommended by me.

Orthodontist's Signature: ____ Date:______________________________

Orthodontist's Name: ____

Address:____

Phone: (   ) ______________________________ Email: ____

APPLICATION FOR MEDICAL AID

AGREEMENT OF APPLICANT, PARENTS/GUARDIAN

In making application for aid, I hereby agree to give my written consent for self or minor child to receive treatment as requested. I recognize the medical need of self or my child indicated herein by Dr.________________________________.

For medical, dental and/or Dr. ________________________________ for orthodontia as advisable and I/We are requesting medical, dental or orthodontia aid, with the understanding that all changes require prior Board approval.

____

Applicant

____

Father or Guardian

____

Mother or Guardian

The success of orthodontic treatment relies heavily on co-operation from the individual being treated.

- All scheduled appointment must be kept. If you are unable to keep your appointment, please call the orthodontist's office ahead of time and reschedule your appointment.

- Maintain good oral hygiene as instructed by your Dentist and your Orthodontist. Perkins Foundation will pay for routine dental cleaning appointments, if there is no insurance to assist.

The Perkins Foundation is dedicated in providing assistance for Dental care in those of need.

If there is noncompliance for treatment from either the Orthodontist or the Dentist, Perkins Foundation will be notified and any remainder payment for treatment(s) will be voided.

By signing below, we acknowledge that we understand and agree to the policy described above.

ACCEPTED AND AGREED:

Parent/Guardian: ____________________________________ Date _____________________________

Parent/Guardian: ____________________________________ Date _____________________________

Patient: ____________________________________ Date _____________________________

Orthodontist: ____________________________________ Date _____________________________

Dentist: ____________________________________ Date _____________________________

APPLICATION FOR MEDICAL AID

ACTION OF TRUSTEES

MEDICAL – DENTAL

We, the Trustees of the B.F. and Rose H. Perkins Foundation have duly investigated the eligibility of the named applicant for medical – dental aid. The Trustees have found the applicant to be ______eligible ______ineligible for aid in accordance with the requirements of the Foundation and the application is hereby approved/disapproved for the sum of: $____.

____

CHAIRMAN

____

____

____

____

ACTION OF TRUSTEES

ORTHODONTIA

We, the Trustees of the B.F. and Rose H. Perkins Foundation have duly investigated the eligibility of the named applicant for orthodontic aid. The Trustees have found the applicant to be ______eligible ______ineligible for aid in accordance with the requirements of the Foundation and the application is hereby approved/disapproved for the sum of: $____.

____

CHAIRMAN

____

____

____

____

Financial need:

______ ______ ______

______ ______