Cleft Smile.org

Cleft Lip & Palate **Foundation of Smiles**

Thank you for contacting the Cleft Lip and Palate Foundation of Smiles regarding the request for special feeding bottles. We hope we can offer assistance to you and look forward getting to know you and your family. All of the information on page two of this application request is required for consideration to receive Special Feeders from the Cleft Lip and Palate Foundation of Smiles. Applications are reviewed within 3-5 business days and applications are reviewed in the order they were received. If you have questions about this application, please contact Rachel@cleftsmile.org.

The Cleft Lip and Palate Foundation of Smiles, does their very best to provide special feeders to those most in need. Therefore, your application does not guarantee the Cleft Lip and Palate Foundation of Smiles can cover the cost or a portion of your special feeders.

We may not be able to respond to all requests and will not be able to provide special feeders to all who make a request. By filling out this application, you do so with the understanding that you may not receive a special feeder and all bottles are given with the Cleft Lip and Palate Foundation of Smile's discretion.

Once completed, the application and supporting documents should be sent to us for review:

1. Email the completed application and support documents to Rachel@cleftsmile.org
2. Or by mail to:

Cleft Lip and Palate Foundation of Smiles Inc.
Attention: Rachel Mancuso
1270 Blanchard SW
Wyoming, MI 49509

Cleft Smile.org
Cleft Lip & Palate Foundation of Smiles

Weimer Bottle Application Form 2013 -2015

Personal Information

Parent's First Name_____ Parent's Last Name_____

Organization, Foundation or Corporation _____

Reason For Request _____

Home Phone Number _____ Cell Phone Number_____

Address_____

City_____ State/ Country/ Providence_____ Postal Code_____

Child's First Name_____ Child's Last Name_____

Date of Birth_____ Child's Next Surgery_____

Child's Address, If Different From Above _____

City_____ State/Providence_____ Country _____ Postal Code_____

Please describe your child's craniofacial diagnosis (Ex. *Cleft Palate, Cleft Lip and Palate, Bi Lateral Unilateral Cleft Lip & Palate, Bell's Palsy, etc.)* _____

_____

_____

_____

Craniofacial Team and Doctor

Craniofacial Team Name _____ Team's Phone_____

Craniofacial Doctor _____ Address_____

City_____ State/Providence_____ Country _____ Postal Code_____

Craniofacial Hospital _____ Address _____

City_____ State/Providence_____ Country _____ Postal Code_____

Health Care Provider

Health Care Provider's Name _____ Provider's Phone _____

Can you provide a written order from your health care provider?

☐ Yes, I have attached a copy of the written order.

☐ No, I don't have a written order.

☐ I need assistance getting a prescription to cover the cost of the bottles and/or getting my insurance to cover the cost of the feeding supplies. I have included with this application the Hippa Waiver.

Insurance Coverage

Has your insurance company denied payment for the special feeding bottles?

☐ Yes, I've attached the denial letter.

☐ No denial.

☐ We don't have insurance.

Type of special feeder you are requesting:

☐ Enfamil Cleft Palate Nurser by, Mead-Johnson

☐ Pigeon Bottle by, Respironics

☐ Haberman Special Needs Bottle, by Medela

☐ Other _____

☐ Sippy Cup *(brand requested)* _____

Have you tried any other type of Sippy Cup?

☐ No

☐ Yes, we've tried the folloing sippy cups: _____

Where would you like the bottles sent to if your application is approved?

Address_____

City_____ State/ Country/ Providence_____ Postal Code_____

_____ _____

Signature of patient or personal representative Date Signed

_____ _____

Printed name of patient or personal representative Relationship to Patient

Application Status

Application Approved By: _____ Date: _____

Date of Shipment of Request: _____

Application Denied By: _____ Date: _____

Notes: _____

_____

_____

_____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.Parts 160 and 164).

****1. Authorization****

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to the Cleft Lip & Palate Foundation of Smiles.

****2. Effective Period****

This authorization for release of information covers the period of healthcare from: _____ to _____.

****3. Extent of Authorization****

a. ☐ I authorize the release of the Name of the Health Care Provider, doctors, written order of the Prescription(s) of the Special feeder Device(s) needed and Craniofacial Diagnosis.

4. This medical information may be used by the Cleft Lip & Palate Foundation of Smiles only to confirm the need of the special needs feeder which will help the foundation determine if I qualify for discounted or complementary bottles supplied by the foundation. Information may only be used for other purposes as I may direct.
5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
9. The Cleft Lip & Palate Foundation of Smiles must not share this information with any 3rd parties. The Cleft Lip & Palate Foundation of Smiles must destroy copies of these records within 90 days of receipt.
10. Even though I am authorizing release of these records, I understand that there is no obligation on the part of the Cleft Lip & Palate Foundation of Smiles to provide to me a special feeding bottle and that there is no guarantee that they will be able to fulfill my request for a special feeding bottle.

_____ _____

Signature of patient or personal representative | Date Signed

_____ _____

Printed name of patient or personal representative | Relationship to Patient