Face to Face Foundation Medical Grant Application

1. Name of the Child:

2. DOB (MM/DD/YY):

3. County you reside in:

4. What is your child's Cleft Diagnosis?

5. Is your child a patient of an ACPA approved team? Yes ☐ No ☐

6. Describe your child's surgical history, and the out of pocket cost associated:

7. Describe your child's nonsurgical history (dentistry, speech therapy, orthodontics, etc.), and the out of pocket cost associated:

8. What is your child's greatest current treatment need?:

9. Please estimate the cost of that treatment. If possible, include a treatment estimate from your provider:

10. Please estimate your annual household income, and number of dependents:

11. How did you learn about the Face to Face Foundation?:

Please fill out this form and email it to rkapitan@mycenters.com Attn: Rick Kapitan

Tell us more about your child's/family's journey and how you feel that the Face to Face Foundation can respond:

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