Beautiful Faces Foundation PETALS Application

Thank you for your interest in PETALS Prosthetic Bra Program offered by Beautiful Faces Foundation
Submission request must include:

- A complete application
- A conformation of your surgery within 12 months of the date of your submission.

Acceptable forms of diagnosis and surgery conformation can be a note or order from your treating physician or surgical discharge forms.

PETALS will provide 3 (three) bras at no cost to the applicant. The service will include

- A fitting
- Your choice of brand selection
- Breast forms
- Pocketing if required

You can submit a confirmed retail or online vendor of your choice, or we are happy to have one of our care coordinators arrange an appointment at one of our preferred vendors In your area.

PLEASE PRINT IN BLUE OR BLACK INK OR TYPE:

Full Name: _____ **DOB:** _____ **Gender:** □ **Male** □ **Female**

Address:_____**City**:_____**State**:_____**Zip**_____

Home Phone (_____) _____ **Work** (_____) _____ **Cell** (_____)_____

Email: _____@_____. _____

Preferred Language: _____ **How did you learn of Beautiful Faces Foundation?** _____

Name of person submitting application _____

What is your relationship to the applicant? _____

Marital Status: □ Minor □Single □ Married □ Widowed □ Separated □ Divorced □ Partner

Employment Status: □Full Time □ Part Time □ Not Employed □ Self Employed □ Retired

Student Status: □ Full Time Student □ Part Time Student □ Not a Student

Have you applied for any similar assistance? _____ Yes _____ No
If Yes: What other assistance have you applied for?

What other assistance have you received within the last 6-12 months?
Please provide details

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Date of your diagnosis _____

Date(s) of all surgeries within the last 12 months _____

Do you have health insurance? ☐ Yes ☐ No Name of Insurance Carrier(s) _____

☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Public Health Insurance ☐ Charity Care ☐ VA insurance program

Have you utilized the prosthesis allowance provided by your insurance plan? ☐ Yes ☐ No

Please share with us if you have a local bra vendor you prefer to use or if you would like us to connect you with our retailer closest to you for your bra selections.

☐ Yes, I have a vendor I'd like to use/ Name & Location of your requested vendor

_____

☐ Please match me with a local retailer for my selections

Hello, nice to Meet You!
Please tell us about yourself, your family, and the challenges you are facing.
Include how you would like us to help you, attach an additional sheet of paper if needed.
Photos are always welcome however **will not be returned** and will become a part of your application submission.

Consent and Agreement

I certify that to the best of my knowledge the information in this application is accurate. I give permission for applicant's information provided on all pages of this application to be reviewed by Beautiful Faces Foundation, Inc. for consideration of assistance.

I certify that I have read and understand all instructions and have provided all requested information. I understand and consent to all information submitted being verified for accuracy by Beautiful Faces Foundation, Inc.
I understand that any false, misleading or missing information will cause my application to be discarded or returned.

Signature_____

Print Name_____

Date _____

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Internal Use Only:

Date Received: _____ Reviewed by: _____

Committee Review Notes:

Approved/Denied _____ Pending Reason: _____

Approved Amount _____ Disbursement Dates/ Details: _____