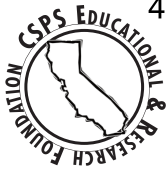
California Society of Plastic Surgeons Educational and Research Foundation (CSPSERF)
4269 Valley View Road, El Sobrante, CA 94803 T: (510) 243-1662



Submit Completed Form to:
Email: cspserf@att.net
Fax: (510) 243-1663

Application Form For Medical Services

Applicant Information

Patient's Name: ____
Please print (Last) (First)

Mailing Address: ____
(Street) (City) (State) (Zip)

Home Phone: (____)________________________

Sex: ☐ **Male** ☐ **Female** **Social Security #:** ____________________ **Date of Birth:** ________________

Name of Parent(s) or Guardian: ____________________ ____________________ ____________________
(Mother) (Father) (Guardian)

Mailing Address of Parent(s)/Guardian: ____
(Street) (City) (State) (Zip)

Daytime Phone Number: (_____)__________________________ **Evening Phone Number: (_____)**__________________________

Cell Phone: (_____)__________________________________ **Email:**____

Language patient/patient's parents/guardian speak?________________

Briefly describe type of surgery or treatment recommended and why:

____

____

The treatment needed is (circle appropriate answer):

a) Related to a congenital birth defect b) Related to an accident or trauma c) Caused by physical abuse d) Caused by violent act

Other health problems? ____

Any Allergies? ____

List any medications currently taking:

____

Has the prospective patient ever received any treatment for the problem? ☐ **Yes** ☐ **No**
[Parent/Guardian needs to obtain copies of all medical records and current front and side-view photographs. The records and photographs should be forwarded with application. Email with scan of completed application, medical records, and photo files (i.e. jpg, png) are accepted.]

Name of Primary Care Physician: ___________________________________

Physician Address: ____
(Street) (City) (State) (Zip)

Physician Phone: (_____)____

Does the patient have medical insurance coverage? ☐ **Yes** ☐ **No**
If yes, please include a copy of your insurance identification card (both sides) and your policy listing the services that you are requesting are not covered.

Specify type: State-subsidized program (e.g. Medi-Cal)___________________________________

Private Insurance: ________________________ Group #: _____________ Subscriber #: ____________________

Other:_______________________________________

If patient has medical coverage, has the insurance denied the care you seek for your child? ☐ **Yes** ☐ **No**
If so, please include a copy of the denial letter.

Financial Information

List of Patient & Family Members	Income Source/ Type of Employment	Age	Relation to Patient	Gross Yearly Income	Check if Person is a Dependent
Include SSI, SSD, SS, IHSS, Alimony, Child Support, Pension, Retirement, and other types of regular assistance.					
Total Household Gross Annual Income:					

PLEASE ATTACH A COPY OF THE MOST CURRENT FILED IRS TAX RETURN.

PLEASE MARK ONE:

_____ *RENT* MONTHLY RENT $________________

_____ *OWN HOME* MONTHLY MORTGAGE PAYMENT $________________

Current Assets (What You Own)	Amount $	Liabilities (What You Owe)	Amount $
House		*Mortgage*	
Savings		*Loans*	
Stocks/Bonds/Investments		*Credit Cards*	
Other		*Other*	
Total Assets		Total Liabilities	

How did you learn about CSPSERF? ____

Please return completed application along with current front and side view photographs (4" x 6" or 5" x 7") to the address above or email to cspserf@att.net (jpg, png, etc files of the patient are accepted). Photographs become the property of CSPSERF and cannot be returned. Applications without photographs cannot be processed. Please call (510) 243-1662 for more information.

I declare under the penalty of perjury that the foregoing is a true and accurate statement as to the availability of any insurance or state funded reimbursements for the surgery requested of CSPSERF.

Parent/Guardian Signature:

____

Printed Name:

____

Date: ________________________________

OFFICE USE ONLY
Patient Application Form Received (date):____________________
Application sent to the Surgery Review Committee for review on (date): ______________________