Serving children with disabilities, one smile at a time!

CalebSmiles

Child's Last Name | Child's First Name | Childs Date of Birth

Childs Diagnosis: _____

Describe your request: _____

What is the approximate cost? _____

Contact information for the vendor or establishment (if known) _____

Parent/Guardian Last Name First Name

Parent/Guardian Last Name First Name

Address | City | State | Zip Code

Home Phone Number | Cell Phone Number | Email

Date | Parent/Guardian Signature

Date | Parent/Guardian Signature

Do you have Insurance? Yes or No

Will your insurance cover any of the cost? Yes or No

*If no, please attach documentation of insurance denial

If requesting equipment, have you worked with a therapist on the evaluation for it? Yes or No

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Someone from Caleb Smiles will contact you to discuss your request further. You will be asked to confirm the age and diagnosis of your child and your financial need will be assessed. Certain medical or financial documents may be requested to verify information. Upon completion of the evaluation, all information will be reviewed and a determination of assistance will be made.

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**Voluntary Media Release**

I (we) grant Caleb Smiles the unrestricted right to edit, use and publish any pictures, images or videos for any and all non-profit purposes. This includes publicity, media interviews, brochures, web site, newsletters or any printed material directly related to the organization for any repurpose. The Child's first name may be utilized, but his/her last name will not be used for any purpose.

It is my (our) understanding that my (our) signature(s) below releases Caleb Smiles from any financial or legal responsibility for the use of this media relations/ promotional material(s).

_____

Date Parent/Guardian Signature

_____

Date Parent/Guardian Signature

*** All Information contained on this application will be kept confidential. No part of this application will be used for any other purposes, other than to determine eligibility for Caleb Smiles to help your child.