Icing Smiles, Inc. Medical Eligibility Form

Please complete the top section of this form and have your child's physician complete, stamp and sign the bottom section. If you have not yet completed the online application, please do so at http://www.icingsmiles.org/receive-smile

Medical Child's Name: _____ Date of Birth: _____/_____/_____

Parent/Guardian Name: _____

Parent/Guardian Email: _____

Parent/Guardian Phone Number: _____

TO BE COMPLETED BY THE MEDICAL TEAM:

☐ **Patient is eligible based on medical condition.**
The child has a life-threatening medical condition that is considered progressive, degenerative, or malignant, **and** that they are within 2 years of their most recent treatment.

☐ **Patient is eligible based on hospitalizations.**
The child requires frequent or extended hospitalizations and is within 1 year of their last inpatient stay. *{14 days or longer OR more than 4 hospitalizations in a 1-year period}*

☐ **Patient is NOT eligible.**

Medical Team Member Name: _____ Phone: _____

Hospital Affiliation: _____

Email Address: _____

Hospital/Clinic Address_____

Patient's Diagnosis (optional): _____

Office Stamp or Patient Label in the box below, or fax Cover sheet with office/patient information is REQUIRED:

_____

Signature of Physician, PA, ARNP, Social Worker **Date**

Please sign, date, & circle your role

Please call with any questions and/or return completed form to:
Phone: 561-593-8314 - Email: icingsmiles@icingsmiles.org - Fax: 866-724-9389