The Pediatric Orthopaedic Fund

The purpose of the Pediatric Orthopaedic Fund (POF) is to provide grants for orthopaedic related medical costs on a reduced fee basis for children who do not have insurance or the means to pay for services. Those with high deductibles will also be considered on a case by case basis.

Grant Guidelines

1. Applicant must be 18 years of age or less
2. Applicant must be a resident of St. Johns County
3. Applicant must be a full-time student
4. Applicant will complete the POF application and supply necessary documentation
5. Applications will be reviewed by Foundation staff and the POF committee. The applicant's physician may be consulted
6. Grant will be for acute care only

FLAGLER HEALTH CARE FOUNDATION

Quality Compassionate Care

The Pediatric Orthopaedic Fund
Grant Application
Please print clearly

PediatricOrthopaedicFund

FLAGLER HEALTH CARE FOUNDATION, INC.

www.flaglerhealthcarefoundation.org

Date: _____

Please Submit the Following Documents *If Applicable* **(Photocopies Only):**

- Two of the most recent pay stubs from both the Guardian and Secondary Adult **OR** a letter from your employer(s) on company letterhead stating your monthly gross income
- Court ordered child support, subsidized housing, social security, food stamps, school loans/grants or other sources of income
- Statement of medical need from attending physician
- Billing statement from medical provider(s)
- A personal letter explaining your need for assistance

Child's Information

First Name:	M.I.:	Last Name:		Date of Birth:	
Street Address:	Apt.:	City:		State:	Zip Code:

Guardian's Information

First Name:	M.I.:	Last Name:
Phone:	Employment Status: (Full Time, Part Time, Self Employed, Unemployed)	

Secondary Adult's Information *If Applicable*

First Name:	M.I.:	Last Name:
Phone:	Employment Status: (Full Time, Part Time, Self Employed, Unemployed)	

Other Dependent(s) *If Applicable*

Name	Age

Medical Provider's Information *If Applicable*

Name:
Address:
Phone: Fax:

Health Insurance Information *If Applicable*

Provider:	
Plan:	
Premium	$
Deductible	$

Please Itemize Your Gross Annual Household Income

This information is kept confidential and will not be used for any other purpose

Salary	$
Child Support	$
Aid for Dependent Child/Children	$
Food Stamps	$
Alimony	$
Other:	$
Total	**$**

Please Answer The Following:

Is the child eligible for the Free or Reduced Lunch program? ___ Yes: ( )Free ( ) Reduced ___ No

Name of the school the child attends: _____

How much do you feel you are able to pay for your child's medical care? $_____

Have you ever applied for the Pediatric Orthopaedic Fund grant? ___ Yes ___ No

If yes, child's name: _____

I certify that the information provided is true and complete to the best of my knowledge.

Signature of Guardian_____ **Date**_____

Please submit completed applications and required documents to one of the locations listed below:

Drop Off

Flagler Health Care Foundation
Flagler Hospital: Anderson-Gibbs Building
301 Health Park Blvd., Ste. 112
St. Augustine, FL 32086

Drop Off, Mail, Fax or E-mail

Orthopaedic Associates of St. Augustine
One Orthopaedic Pl.
St. Augustine, FL 32086
Fax: (904) 209-1055 * pof@oastaug.com

Questions? Please call (904) 819-4625