Instructions for Completing this Application

Application to the Educational and Research Foundation for the American Academy of Facial Plastic and Reconstructive Surgery, FACE TO FACE: National Domestic Violence Project in Partnership with Break the Silence Foundation

The AAFPRS FACE TO FACE National Domestic Violence Project was created to connect survivors of domestic violence to board certified facial plastic surgeons who are members of the AAFPRS. Assistance may be available for a those who need medical treatment or services to repair injuries of the head and/or neck, inflicted by an abusive spouse, intimate partner, sibling or parent. Break the Silence Foundation assists survivors with the application process and partners with the AAFPRS to identify a potential physician that may assist the survivor identified needs.

APPLICANTS MUST MEET ALL THE FOLLOWING GUIDELINES TO QUALIFY FOR SERVICES

1. **The applicant must have received the physical injuries from an abusive intimate partner, spouse, parent or sibling.** For example: husband, wife, partner, boyfriend, girlfriend, sister, brother, mother or father. If the injury was caused by violent attacks, stranger assault or accidental injury not related to domestic violence, the application will be denied.
2. **The applicant must be out of the situation for at least twelve months**. If the applicant is not out of the situation, then the application will not be considered until such time the applicant meets this requirement.
3. **All applicants must have had contact with a domestic violence advocate, social worker, case manager, counselor, faith leader or therapist a minimum of (2) two times and this individual or organization must provide you with a typed letter summarizing you are ready to begin the physical aspects of your healing process. This letter must include the following:**
    a. Name, title and/or organization (preferably on letterhead)
    b. Confirm that you have had more than one session
    c. Ascertain that they believe your injuries were caused by domestic violence
    d. Ascertain that they believe you are no longer experiencing domestic violence
    e. And, that you have been out of the domestic violence situation a minimum of twelve months.
    f. Signature and dated

NOTE: You may schedule a minimum of two interviews with the Break the Silence Foundation advocate in lieu of a letter.

You will need a scanned copy of this letter to include with this application. Please scan and not take a photo with your phone.

The applicant may either see someone they have worked with in the past that is willing to reconnect with you for the purposes of this application, or seek a referral to a local domestic violence program to find an advocate, case manager, etc. that will support the applicant with this process.

The purpose is to have an independent source confirm that the applicant received their injuries during a domestic violence situation, that the applicant has now been out of the abusive relationship for a minimum of twelve months, and in his/her professional opinion has begun the emotional healing and is ready to consider the physical healing in steps to regain their normal life.

If your advocate, case manager, social worker, counselor, therapist or faith leader need more information about the FACE TO FACE Program, please have them contact BTSF at (800) 257-4766. To find the phone number to a local domestic violence program, call the National Domestic Violence hotline at 1-800-799-7233 or connect with your state coalition to find a domestic violence service provider https://ncadv.org.

STOP: **If you need someone to help you fill out this application, contact BTSF at (800) 257-4766.**

PLEASE FILL OUT ALL SECTIONS COMPLETELY AS DIRECTED.

Note that the application will not be accepted if all required fields are not completed.

Name

Mailing Address City

State Zip Phone

E-Mail address

If you change your address or phone number, notify BTSF as soon as possible. Your standing in the program could be jeopardized if we cannot contact you. If you do not have a safe phone number, please provide a phone number where we can leave a message.

We are often asked about the demographics of those we serve. *The following questions are optional, but helpful to our work at BTSF and the AAFPRS Foundation.*

Please check the gender with which you identify: Male ☐ Female ☐ Prefer not to Identify ☐

Are you a veteran? Yes ☐ No ☐

If yes, you may qualify for our FACES OF HONOR Program. A staff member will contact you to discuss further options.

What is your ethnicity?

Caucasian ☐ Black or African American ☐ American Indian or Alaska Native ☐

Asian or Middle Eastern ☐ Native Hawaiian or Other Pacific Islander ☐

Hispanic or Latino ☐ Multiracial ☐ Other ☐ Decline to Disclose ☐

What is your Age Group:

18-25 ☐ 25-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ 70+ ☐

If selected as a candidate, do you require any special accomodations? Yes ◯ No ◯

If yes, explain:

The following questions are required:

1. Are you able to pay for any of the consultation or procedures or do you have any insurance that might offset any costs? Yes ◯ No ◯

2. For funding purposes, we must demonstrate the level of family income for referred patients. Please indicate youwr family income level (check one):

Less than $20,000 ☐	$20,000 to $24,999 ☐	$25,000 to $29,999 ☐
$30,000 to $34,999 ☐	$35,000 to $39,999 ☐	$40,000 to $44,999 ☐
$50,000 to $54,999 ☐	Greater than $55,000 ☐	

Your current occupation:

Have you had prior cosmetic or reconstructive surgery? Yes ◯ No ◯ If Yes explain

Please fill out the following ONLY if reports were made.

Police Reports number Protection Order number(s)

Are you including? Yes ◯ No ◯ If yes, please include as a separate pdf. in your e-mail

Please describe your scars and/or injuries as succinctly as possible. Remember our physicians only treat head and neck injuries and they must have been incurred during a domestic violence incident. Use only the space below to describe your head and/or neck scars and/or injuries. You may include 1-2 photos of yor scars or injuries as a jpg, tif or png. Please submit photos separately in the e-mail.

How did you hear about this program? Friend ☐ Internet search ☐
Newspaper ☐ Magazine ☐ Agency ☐ Radio ☐ Other ☐

The information in this application is strictly confidential, and it will not be released without your consent.

Please review the *Authorization and Release for Referral of Patient and Use of Information and Images* below and carefully complete, initial and sign where noted. This form is **required** in order for BTSF and the AAFPRS Foundation to meet HIPAA requirements as relates to your medical information and we cannot accept your application without a signed release form.

I verify that the statements on this application are true. I authorize release of this information to BTSF, the AAFPRS Foundation and medical professionals providing the medical care needed to repair the damage caused by domestic violence. I give permission to BTSF to contact me to discuss and review any aspects of this application. By typing my full name below and dating, I attest that I agree to the above.

Signature: **Date:**

AUTHORIZATION AND RELEASE FOR REFERRAL OF PATIENT AND USE OF INFORMATION AND IMAGES

Please complete and/or check all sections and electronically sign and date

I , _____ (print name) am applying for a referral to a physician through the FACE TO FACE program of the Educational and Research Foundation for the American Academy of Facial Plastic and Reconstructive Surgery ("the Foundation") and Break the Silence Foundation (BTSF). The Foundation is affiliated with the American Academy of Facial Plastic and Reconstructive Surgery (its "affiliated Academy"). BTSF is a separate 501c3 entity in partnership with the Foundation.

☐ In the course of that referral and any subsequent treatment, the Foundation and BTSF may disclose medical, health and other information about the undersigned to physicians' offices. In signing this application, the applicant acknowledges and consents to the following:

☐ The undersigned consents to those disclosures.

☐ The undersigned understands that the Foundation and BTSF do provide medical or surgical services. BTSF reviews applications and refers some patients for those services to the Foundation to assign to a volunteer physician. Nothing in this authorization and release obligates the BTSF to make any such referral or the Foundation to accept the referral. The sole provider of medical and surgical services will be the treating physician, if a referral occurs.

☐ The undersigned agrees to look solely to treating physician for services and will make no claim against the Foundation, its affiliated Academy or BTSF.

☐ The undersigned grants to the treating physician, the Foundation, its affiliated Academy and BTSF the on-going and unrestricted right to use any medical information, photographs and video supplied by the undersigned or occurring in treatment for general information, education, scientific and medical purposes and to permit others to use them for those purposes.

☐ The undersigned also authorizes the treating physician, the Foundation, its affiliated Academy and BTSF he use and display of said medical information, photographs and video in any public relations, publication, multimedia production, display, advertisement, database, Internet Broadcast or Internet Publication.

☐ The undersigned further acknowledges that he/she relinquishes all right, title, and interest in such medical information, photographs or that video, or any right to profit or gain directly or indirectly realized through the use of the photographs or video. The persons to whom disclosure may be made include physicians, medical students, patients and prospective patients, examining boards, medical and other periodicals, medical editors, insurers (if any), outside firms, the staff of the Foundation and its affiliated Academy, readers of medical literature, BTSF staff and the general public.

☐ The undersigned releases the Foundation, its affiliated Academy, BTSF, their officers, directors, employees and members from any liability of any kind whatsoever arising out of or relating to use of the photographs or video.

☐ This authorization may only be revoked in writing, signed by the undersigned and delivered to the physician, the Foundation at its office in Alexandria, Virginia and BTSF in Cermak, IL. Such revocation shall thereafter be effective as to any further use not already committed to by the physician or the Foundation or its affiliated Academy. Unless earlier revoked, this authorization will expire on the end of the Foundation's and BTSF's operation of referral programs, except there will be no expiration for the purpose of medical or scientific research. Revocation will not affect uses and disclosures made before receipt of the revocation. Revocation does not affect the commitments in the third paragraph of this document. If the medical information, photographs or video are disclosed, there is obviously potential for redisclosure some of which would not be subject to this authorization. Photographs, as used in this document, include digital images. This authorization includes uses on the Internet and websites.

☐ This authorization is in consideration of the Foundation's review and possible referral of undersigned patient and of services performed and consultations conducted or to be performed or conducted by the physician, and there have been no representations or inducements concerning this authorization except as set forth herein. The treating physician will not condition treatment on whether the individual authorizes use of medical information, video and photographs, but, if any portion of the treating physician's services is to be covered under any insurance or third-party-payment plan, the signing individual will be responsible for authorizing release as required by that insurance or third-party payment plan. Please indicate you agree by typing your full name and date below.

Name Date

STOP! BEFORE YOU SAVE YOUR DOCUMENT PLEASE READ THE FOLLOWING:

1. Be sure all sections of this application are filled out completely before saving and emailing to BTSF.
2. Make sure you are seen by a counselor, domestic violence advocate, social worker, therapist, case manager or counselor, etc. and have a scanned copy their letter of support to include with the application.
3. Be sure to digitally sign, initial and date all sections as noted.
4. Include any letter of support, police reports or orders of protection or photos as separate documents in your e-mail.
5. It is suggested that you make a copy of this application for your files.
6. If your address or phone number changes, please call (800) 257-4766. You may also email us at **ftfapp@btsfinc.org**

WHAT HAPPENS AFTER I MAIL MY APPLICATION?

- Once your e-mailed application is submitted, you will receive an e-mail confirmation.
- Once your application is received, and it is determined that you qualify; you will be notified in writing by BTSF that your application was accepted by BTSF and forwarded to the AAFPRS FACE TO FACE DV Program for review and consideration.
- The AAFPRS will source volunteer physicians in your area to determine if a physician is available to see you for a consultation. If one is located, the AAFPRS will provide BTSF with the contact information.

WHAT HAPPENS IF MY APPLICATION IS ACCEPTED?

- BTSF will contact you with a referral to a medical professional as close to you as possible. Please know this process takes time, and it may take several weeks before you are contacted with a referral. *It is your responsibility to reach out to the physician contact to set the consultation appointment.*

- There is no guarantee that you will be able to benefit from this program until you see the medical professional for the first consultation. If you must cancel an appointment for any reason, notify the medical professional's office directly (*failing to show up for an appointment without calling could jeopardize your standing in the program*).

- While the medical professionals directly assisting you are volunteering their services, there is no guarantee that other services will also be free (hospital stays, prescriptions, anesthesiologists, x-rays, follow-up treatment, etc.). Talk with your doctor and/or advocate, case manager, social worker, etc. about how these costs can be reduced or eliminated.

- PLEASE NOTE: You may be able to use your health insurance, Medicaid or Victim's Compensation to help with other costs; be sure to verify this prior to any services you receive. Costs incurred by you are not reimbursable by the Break the Silence Foundation, the AAFPRS Foundation and/or the medical professionals, service providers and/or partner agencies.

CONGRATULATIONS! YOU ARE DONE. IF YOU ARE READY, SAVE THIS COMPLETED APPLICATION PDF AND E-MAIL WITH ANY LETTERS OF SUPPORT, SUPPORTING DOCUMENTS AND/OR PHOTOS IN ITS ENTIRETY TO

ftfapp@btsfinc.org

AND YOU APPLICATION IS ON ITS WAY!