



## VALLEY OF JOPLIN SCOTTISH RITE CARE

Valley of Joplin Scottish Rite  
505 S Byers, Joplin, MO 65801

### APPLICATION FOR ASSISTANCE

#### Summary of Assistance Requested

Date \_\_\_\_\_

1. Name of child needing assistance: \_\_\_\_\_ Age \_\_\_\_\_

2. Name(s) of parent(s)/ legal guardian \_\_\_\_\_

\_\_\_\_\_

3. Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Phone \_\_\_\_\_

\_\_\_\_\_

5. Email \_\_\_\_\_

#### 6. Detail of assistance needed:

(Include a short summary of the medical condition, what will need to be funded, and amount of funding being requested)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### 7. Medical Provider

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_



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### APPLICATION FOR ASSISTANCE

#### SECTION I

1. Name of Child \_\_\_\_\_  
Last First Middle

2. Residence of Child \_\_\_\_\_  
Street No. Street City/Town State/Province Zip code

3. Age: \_\_\_\_\_ Sex \_\_\_\_\_ Birth Date \_\_\_\_\_  
Month Day Year

4. Name of Father \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_  
Street No. Street City/Town State/Province Zip code

Contact Number: \_\_\_\_\_  
Area Code. Phone Number

Marital Status:  Single  Married  Separated  Divorced or Widowed

5. Name of Mother \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_  
Street No. Street City/Town State/Province Zip code

Contact Number: \_\_\_\_\_  
Area Code. Phone Number

Marital Status:  Single  Married  Separated  Divorced or Widowed

6. Legal Guardian (if different from above) \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_  
Street No. Street City/Town State/Province Zip code

Contact Number: \_\_\_\_\_  
Area Code. Phone Number

Marital Status:  Single  Married  Separated  Divorced or Widowed

7. Nature of Disorder: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Has previous treatment been received from Scottish Rite Clinic?  Yes  No

If "yes", give name of Clinic, and approximate date of application \_\_\_\_\_

**If child is presently under doctor's care, please have him/her complete Section IV of this form. If the child is not presently under doctor's care, give name, address and telephone number of physician who last treated the child:**

\_\_\_\_\_  
Physician's Name Address Phone No.

**SECTION II (To be completed by Applicants Parents or Legal Guardian)**

1. Number of dependent children \_\_\_\_\_ Ages \_\_\_\_\_

Father/Legal Guardian

Mother

2. Name of Employer \_\_\_\_\_

3. Address of Employer \_\_\_\_\_

4. Date Employed \_\_\_\_\_

5. Exact kind of work: (check one) \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time

6. Present take-home pay in each check \$ \_\_\_\_\_ Weekly \_\_\_\_\_ Bi-Monthly \$ \_\_\_\_\_ Weekly \_\_\_\_\_ Bi-Monthly

7. Give yearly income from any other source \$ \_\_\_\_\_ \$ \_\_\_\_\_  
Indicate Source \_\_\_\_\_

8. Total taxable income according to last year's tax return \$ \_\_\_\_\_ \$ \_\_\_\_\_

9. Previous Employer \_\_\_\_\_

10. How long employed \_\_\_\_\_

11. Previous Salary \$ \_\_\_\_\_ \$ \_\_\_\_\_

12. List assets of both parents or legal guardian (excluding home and automobile): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. Do you rent your principal residence? \_\_\_\_\_ Monthly rental payment \$ \_\_\_\_\_

14. Do you own your own home? \_\_\_\_\_ Monthly mortgage payment \$ \_\_\_\_\_

15. Is this child covered by medical or hospitalization insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No

17 If there is coverage by both parents' employers, indicate both companies.

a. Father's insurance company: Name of company \_\_\_\_\_  
Policy number \_\_\_\_\_

b. Mother's insurance company: Name of company \_\_\_\_\_  
Policy number \_\_\_\_\_

17. Do you presently owe for any medical treatment for this child not covered by insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No

Indicate amount: \$ \_\_\_\_\_

18. Have there been any other medical bills in family recently? \_\_\_\_\_ Yes \_\_\_\_\_ No

16. Do you have Medicaid? \_\_\_ Yes \_\_\_ No Has Medicaid or your insurance denied coverage? \_\_\_ Yes \_\_\_ No  
(Attached denial to application)

19. Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Father

\_\_\_\_\_  
Signature of Mother

\_\_\_\_\_  
Signature of Legal Guardian  
(If other than Parents)

**SECTION III**

1. Name of Child \_\_\_\_\_  
Last First Middle

2. Residence of Child \_\_\_\_\_  
Street No. Street City/Town State/Province Zip code

**CONDITIONS OF APPLICATION  
PARENTS OR LEGAL GUARDIAN READ CAREFULLY**

Application is hereby made for the treatment of the above-named child through the Scottish Rite Foundation. Acceptance of the child for examination, treatment or care is upon the conditions, and with the consents, in this application stated.

**I hereby agree as follows:**

- a. To deliver the child to the clinic when requested to do so, and to come for the child immediately upon being notified by the Clinic authorities;
- b. To waive and relinquish any and all claims or liabilities against the Clinics, their associated, affiliated, appendant or parent corporations, and any Scottish Rite Body, or member, or the Club, or Scottish Rite Mason, arising out of or in anywise connected with the transportation of said child, his family or guardian, from one place to another. by whatsoever means, in connection with any examination, treatment or care of said child: and to indemnify such persons, firms or corporations against all loss, cost or expense resulting to any said parties in account of any claim by me or said child.

**Further, in connection with the treatment or care of said child, I hereby consent and authorize:**

- a. Such clinic care encompassing routine diagnostic treatment, including outpatient care as the Chief of Staff or his assistants or designees shall in their judgment deem necessary;
- b. In the event of an emergency, that the child may be transferred by the clinic authorities to any other clinic or facility for care or treatment;

**Acknowledgment of no medical service provided:**

I, \_\_\_\_\_ acknowledge that the Valley of Joplin Scottish Rite Care, Inc. has not provided any medical care to \_\_\_\_\_ my child. I also acknowledge that the Valley of Joplin Scottish Rite Care, Inc., if the application is approved, only provided funding and they do not recommend or provide any form of medical care nor do they recommend or require any specific treatment or provider.

**ALTERING THIS APPLICATION IN ANY WAY WILL RESULT IN DISAPPROVAL**

Signed \_\_\_\_\_ (Father)  
Signed \_\_\_\_\_ (Mother)  
Signed \_\_\_\_\_ (Legal Guardian if applicable)

Witnessed By: \_\_\_\_\_ Date \_\_\_\_\_

(NOTE: if a person other than the parents sign this application, or if the parents are divorced, legal guardianship or control of this child must be established with custodial papers or other appropriate legal documents establishing authority to sign the application.)

**SECTION IV**

**PHYSICIAN'S CERTIFICATE**

Date \_\_\_\_\_

1. Patient's Name \_\_\_\_\_ Age \_\_\_\_\_

2. Describe the disease or disability \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Do you know of any previous treatment patient has received for this condition? \_\_\_\_\_

Describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. Developmental age of child \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

5. Remarks and recommendations \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Physician's Name (Please Print) \_\_\_\_\_

7. Physician's Address \_\_\_\_\_  
Street City/Town State/Province Zip code

8. Signature of Physician \_\_\_\_\_

**SECTION V**

**TO BE COMPLETED AT THE CLINIC  
(If Applicable)**

Clinical Recommendation \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Physician \_\_\_\_\_

**SECTION VI**

**AUTHORIZATION FOR USE OF INFORMATION**

Authorization for use of information (Optional)

I, \_\_\_\_\_, authorize Valley of Joplin Scottish Rite Care, Inc. to use \_\_\_\_\_ born on \_\_\_\_\_ specified medical information related to the care in this application and/or photography/ video/audio recording for the following purpose(s):

	Yes	No
Use in advertising and promotional materials	_____	_____
Media Stories	_____	_____
Fund Raising Events	_____	_____
News Articles	_____	_____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand by signing below, I authorize Valley of Joplin Scottish Rite Care, Inc. to information from my child(s) medical records, such as, but not limited to; pretreatment condition, treatment procedures and therapies, post treatment results.

I understand I may revoke this authorization at any time by signing a Revocation Form and delivering it to the Valley of Joplin Scottish Rite Care, Inc. offices at SOS south Byers in Joplin, Missouri. I further understand that such a revocation does not apply to the extent that persons authorized to use or disclose my child's health information have already acted in reliance on this authorization.

Signed \_\_\_\_\_ (Father)

Signed \_\_\_\_\_ (Mother)

Signed \_\_\_\_\_ (Legal Guardian if applicable)

Witnessed By: \_\_\_\_\_ Date \_\_\_\_\_

**SECTION VII**

**TO BE COMPLETED BY RITE CARE BOARD**

(Office Use Only)

1. Received by Administrator Date \_\_\_\_\_

2. Reviewed by Administrator Date \_\_\_\_\_

3. Administrator's review comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Presented to board Date \_\_\_\_\_

5. Board action: \_\_\_\_\_ Approved

\_\_\_\_\_ Rejected

\_\_\_\_\_ Modified

6. Explain modification: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. Family notification by: \_\_\_\_\_ Date: \_\_\_\_\_

8. Provider notified by: \_\_\_\_\_ Date: \_\_\_\_\_