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: _____

VALLEY OF JOPLIN SCOTTISH RITE CARE

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

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 tor 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 CERTICATE** 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:_____