Phone: 417.347.6639
Fax: 417.347.3783
931 E 32nd St, Ste 3
Joplin, MO 64804
Business hours: Mon – Fri, 8 am – 5 pm

ASSISTANCE BY APPOINTMENT ONLY.
Tuesdays 8:30 am – 12:00 pm
Wednesdays 9:00 am – 1:00 pm & 2:00 pm – 4:30 pm
Thursdays 1:00 pm – 4:30 pm
Must have appointment confirmation to receive assistance.

APPLICATION FOR ASSISTANCE

Children's Miracle Network Hospitals is a charity designed to assist families of sick or injured dependent children 21 years or younger. **Funds are provided after Medicaid and/or private insurance have distributed their resources.**

HOW TO APPLY FOR FUNDING

1. Fill out the application completely and sign it.
2. Attach the appropriate documentation for the assistance you are requesting.
    - Referral letter from Freeman physician
    - Appointment confirmation from hospital/clinic (Kansas City, St. Louis, Springfield)
    - For medication: copy of the prescription and Freeman physician referral
    - For special equipment: letter of medical necessity, Medicaid or insurance denial letter and Freeman physician referral
    - Proof of Residency
    - Verification of appointment attended (Can be faxed, or emailed)
3. Families without private insurance must apply for Medicaid (proof must be provided within 90 days of application)
4. All requests for assistance must be submitted **48 hours** in advance for assistance
5. Re-occurring assistance requires discharge information from prior visit.

CHILDREN'S MIRACLE NETWORK HOSPITALS CANNOT PROVIDE FUNDING FOR:

- Hospital bills, doctor bills, therapy or treatment programs
- Utility bills or hookups
- Reimbursement for expenses not approved in advance
- Any expense not directly related to the medical care of the child
- Lodging Expenses: hotel, Ronald McDonald House or Haven House

I have read the above guidelines and understand that assistance will be determined based on need. I also guarantee the accuracy of all information. Children's Miracle Network Hospitals has my permission to contact all parties involved in order to determine need. Assistance will be terminated if the applicant misuses the assistance or provides false information.

_____ _____

Parent/Legal Guardian Signature Date

Child's name: _____ DOB: _____

Health Insurance Provider(s) or Medicaid #: _____

Legal guardian #1: _____ DOB: _____

Last 4 digits of Social Security #: _____ Email: _____

Address: _____

City/State: _____ Zip: _____County: _____

Home phone: _____ Cell phone: _____

Employer: _____ Time employed: _____

Employer Phone: _____

Legal guardian #2: _____ DOB: _____

Last 4 digits of Social Security #: _____ Email: _____

Address: _____

City/State: _____ Zip: _____County: _____

Home phone: _____Alternate phone: _____

Employer: _____ Time employed_____

Employer Phone: _____

Name and ages of all other household members (excluding the above persons):

_____ _____ _____

_____ _____ _____

Primary pediatrician: _____

Address and phone number: _____

Diagnosis: _____Date diagnosed: _____

Specialist: _____ Appointment time/date: _____

Address and phone number: _____

Hospital: _____

Social worker/Case Manager (if assigned):_____

If you are requesting equipment, please enclose price quotes and a prescription for the equipment from your child's physician. Equipment will be approved or denied on a case-by-case basis.

Equipment requested: _____Letter of Necessity: **YES** **NO**

Lowest price quote: _____Vendor: _____

Contact: _____Phone number: _____

Email address: _____

CMN USE ONLY

_____

_____

_____

_____

_____

_____

_____

_____

_____

AUTHORIZATION FOR USE OF INFORMATION

I, _____, authorize Freeman Health System to use
(Print Name: Parent/Legal Guardian)

_____, born _____, specified medical information
(Print: Patient Name) (date of birth)

and/or photography/video/audio recording.

For the following purpose(s): (please check each appropriate box)

{ } Use in Freeman Health System advertisement

{ } Use by Freeman Health System to market

{ } Media Story

{ } Children's Miracle Network promotional materials

{ } Assistance Approval purposes ONLY

This authorization may be revoked at any time with written notice to CMNH. A photo static or fax copy of this authorization shall be considered as effective and valid as the original.

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 CMNH to collect information from my child(s) medical records, such as, but not limited to; Appointment/Hospital information: dates, confirmations, cancellations, hospital admittance, and future appointments.

I understand I may revoke this authorization at any time by signing a Revocation Form at Freeman Health System and returning it to the Information Privacy/Security Officer. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

Signature: _____ Date: _____
(Parent/Legal Guardian)

CMNH Signature: _____ Date: _____

Application Checklist

☐ Proof of residency; utility bill in your name, property tax or lease agreement

- [ ] Confirmation of appointment from hospital or clinic your child is being seen in

- [ ] Copy of prescription (if requesting medication or equipment)

- [ ] Medical letter of necessity (if requesting equipment)

- [ ] Medicaid or Insurance denial letter (if requesting medication or equipment)

- [ ] Referral letter from physician