



**Children's
Miracle Network
Hospitals**

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417.347.3793

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Office address: 931 E. 32nd St. Joplin, MO 64804

Office hours: 8:30 am - 4:30 pm Monday - Friday*

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 a letter from your child's physician stating the diagnosis.
3. Attach the appropriate documentation for the assistance you are requesting.
 - For travel assistance, attach a confirmation of your child's appointment.
 - For medication, attach a copy of the prescription.
 - For special equipment, attach a letter of medical necessity from your child's doctor.
4. Families without private insurance must apply for Medicaid before applying to your local Children's Miracle Network Hospital.
5. All requests for travel expenses must be submitted **one week** in advance for funding consideration. Travel expenses will only be paid if your child does not qualify for this service through Medicaid. Proof of denial from Medicaid is necessary before your local Children's Miracle Network Hospital can assist.

CHILDREN'S MIRACLE NETWORK HOSPITALS FUNDS MAY BE USED FOR:

- Travel expenses to an appropriate medical facility
- Prescription medicine
- Medical equipment and supplies
- Prostheses, eye glasses, braces, wheelchairs, hearing aids, etc.

CHILDREN'S MIRACLE NETWORK HOSPITALS CANNOT PROVIDE FUNDING FOR:

- Hospital bills, doctor bills, dental 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

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.

Signature (legal guardian)

Date

*Please call 417.347.3793 for an appointment.

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Child's name: _____
Date of birth: _____ Last four digits of Social Security #: _____
Medicaid #: _____
Health insurance provider(s): _____

Legal guardian #1: _____
Date of birth: _____ Last four digits of Social Security #: _____
Address: _____
City: _____ State: _____ Zip: _____ County: _____
Email address: _____
Home phone: _____ Alternate phone: _____
Employer: _____ Years employed: _____
Employer phone: _____
Monthly income (before taxes): _____ Net income: _____
Other sources of income (WIC, food stamps, child support): _____

Legal guardian #2: _____
Date of birth: _____ Last four digits of Social Security #: _____
Address: _____
City: _____ State: _____ Zip: _____ County: _____
Home phone: _____ Alternate phone: _____
Employer: _____ Years employed: _____
Employer phone: _____
Monthly income (before taxes): _____ Net income: _____
Other sources of income (WIC, food stamps, child support): _____

Monthly household expenses:
Mortgage/rent: _____ Utilities: _____
Car payment: _____ Child care: _____
Other expenses to be considered (child support, medical expenses, etc.): _____

Name and ages of all other household members: _____

Are you requesting funding from any other agencies? If so, please explain.

Child's name: _____

Primary pediatrician: _____

Address and phone number: _____

Diagnosis: _____

Date diagnosed: _____

Specialist: _____

Address and phone number: _____

Hospital: _____

Phone number: _____

Social worker (if assigned): _____

If you are requesting travel expenses, please fill out the following.

Doctor: _____

Address and phone number: _____

Date of appointment: _____

Appointment time/date: _____

Reason for appointment: _____

If you are requesting equipment, please enclose three 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: _____

Lowest price quote: _____

Vendor: _____

Phone number: _____

Email address: _____

CMN use only

Case processor notes: _____



AUTHORIZATION FOR USE OF INFORMATION

I, _____, authorize Freeman Health System to use
(patient's name or legal representative here)

_____, born _____, specified medical information
(patient) (date of birth)

and/or photograph/video/audio recording.

List specific information to be used: _____

For the following purpose(s): (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: _____

This authorization expires on _____ or within 6 months of the date signed. A photostatic or fax copy of this authorization shall be considered as effective and valid as the original.

For disclosures for Freeman Health System purposes or from another healthcare provider, Freeman will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits upon my signing of this authorization form and I may refuse to sign this authorization form based upon these types of disclosures.

I understand that I will receive no financial consideration for the granting of this permission.

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

Witness: _____ Date: _____