Contact: Karla Hurrell, 417.347.3793
Fax: 417.347.3783
Mailing address: 1102 W. 32nd St., Joplin, MO 64804
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 (CMN) 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 CMN.
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 CMN can assist.

CMN 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.

CMN IS NOT ABLE TO HELP WITH:

- 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. CMN 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

*We encourage you to call 417.347.3793 for an appointment.

Child's name: ______________________________
Child's date of birth: _________________Social Security #: ________________
Medicaid #: ___________________________
Health insurance provider(s): ____
____

Legal guardian #1: __________________________
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):____________________
____
Total income: __________________

Legal guardian #2: ____________________________
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):____________________
____
Total income: ___________________

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: ___________________________
____

Email address: ___________________________

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: ____
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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: ___________________

Freeman Health System • Marketing Department • 1102 W. 32nd St. Joplin, MO 64804 • 417.347.6621