Contact: Jordan Baker
Programs and Events Specialist
Phone: 417.347.3793
Fax: 417.347.9785
931 East 32nd Street
Joplin, MO 64804

Assistance by appointment, Monday – Friday, 8:00 am – 5:00 pm Must give at least 48 hour notice of upcoming appointments
(Monday - Friday only, the 48 hour notice does not include the weekend) **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
    - Proof of Income
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

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: _____ Monthly income: _____

Other sources of income (WIC, food stamps, childsupport): _____

_____

Total monthly income: _____

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: _____Monthly income: _____

Other sources of income (WIC, food stamps, child support):_____

_____

Total monthly income: _____

Monthly household expenses:

Mortgage/rent: _____Utilities (combined): _____

Car payment: _____Child care: _____

Additional expenses to be considered (child support, medical expenses, etc.):

_____ _____

_____ _____

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

_____ _____ _____

_____ _____ _____

Child's name: _____

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

_____

_____

_____

_____

_____

_____

_____

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_____

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 in Freeman Health System marketing

{} Media Story

{} Children's Miracle Network Hospitals promotional materials

{} Assistance Approval purposes ONLY

This authorization expires within 12 months of the date signed. 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 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 treating your child
- [ ] 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 Freeman physician