Jayde Thomas
Development Assistant
417.347.6658
417.347.3783
931 East 32nd Street
Joplin, MO 64804

Assistance by appointment, 8:00 am – 5:00 pm, Monday – Friday
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 assists families of sick or injured dependent children birth to age 21. Funds are provided after Medicaid and/or private insurance have distributed resources.

HOW TO APPLY FOR FUNDING

1. Compete application and sign it
2. Attach the appropriate documentation for the assistance you are requesting:
   a. Referral letter from Freeman physician
   b. Appointment confirmation from hospital/clinic (Kansas City, St. Louis, Springfield)
   c. For medication: copy of the prescription (referenced above)
   d. For special equipment: letter of medical necessity, Medicaid or insurance denial letter
   e. Proof of Residency
   f. Proof of Income
3. Apply for Medicaid if you do not have private insurance (proof must be provided within 90 days of application)
4. Submit application **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 I misuse the assistance or provide false information.

______________________________ ______________________

Parent/Legal Guardian Signature Date

Child's name:____Date of Birth: ___________

Health insurance provider(s) or Medicaid number: ____

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, child support):___________________________________

____

Total monthly income: ________________________

Legal guardian #2:____ Date of Birth: ___________

Last 4 digits of Social Security number:__________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 considered on a case-by-case basis.

Equipment requested:_____________________________________Letter of necessity: **YES NO**

Lowest price quote:______________________________Vendor: __________________________

Contact:_________________________________Phone number: ___________________________

Email address: ____

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 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)
- [ ] Proof of income (most recent paycheck stubs or last year's tax returns)
- [ ] Confirmation of appointment from hospital or clinic where your child is being seen
- [ ] 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