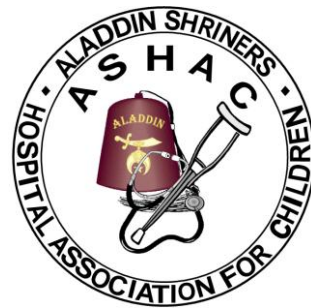


# Hospital Association for Children



## PROGRAM APPLICATION

### CHILD'S INFORMATION

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Mailing Address: \_\_\_\_\_  
(Street)

(City) (State) (Zip) (County)

Phone: \_\_\_\_\_ Sex: Male Female

Birthday: \_\_\_\_\_ Social Security: \_\_\_\_\_

Who does the child live with primarily? (Circle One) Both Parents Mother Father Other

### MOTHER'S INFORMATION

☐ Check if same address as child.

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Mailing Address: \_\_\_\_\_  
(Street) (City) (State) (Zip) (County)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

### FATHER'S INFORMATION

☐ Check if same address as child.

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Mailing Address: \_\_\_\_\_  
(Street) (City) (State) (Zip) (County)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

### LEGAL GUARDIAN

☐ Check if same address as child.

Name (if different from above): \_\_\_\_\_  
(Last) (First) (Middle)

Relationship to Child: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(Street) (City) (State) (Zip) (County)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### SPONSORING SHRINER INFORMATION

Shriner's Name: \_\_\_\_\_  
(Last) (First) (Middle)

Shriner's Address: \_\_\_\_\_  
(Street) (City) (State) (Zip) (County)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Sponsoring Shriner's Signature: \_\_\_\_\_

## MEDICAL INFORMATION

Problem or Diagnosis (if known): \_\_\_\_\_

Date First Noticed: \_\_\_\_\_

Describe Chief Complaint (symptom): \_\_\_\_\_

How long has child had the problem? From Birth \_\_\_\_\_ Developed Recently \_\_\_\_\_

Injury \_\_\_\_\_ Date \_\_\_\_\_

What other symptoms does your child have? \_\_\_\_\_

## Previous Treatment:

Physician: \_\_\_\_\_ Hospital: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Treatment Provided:

Surgery/Dates: \_\_\_\_\_

Other Treatment/Dates: \_\_\_\_\_

X-Rays: Yes \_\_\_\_\_ No \_\_\_\_\_ Date of most recent x-ray: \_\_\_\_\_ (bring to first appointment)

When was the child last seen by a doctor? \_\_\_\_\_

Has the child been treated by another Shriners Hospital? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, Date: \_\_\_\_\_ Location/City: \_\_\_\_\_

## FINANCIAL INFORMATION

Total Combined Family income for the last 12 months:

\_\_\_\_\_ \$0 - \$10,000      \_\_\_\_\_ \$10,001 - \$20,000      \_\_\_\_\_ \$20,001 - \$30,000  
\_\_\_\_\_ \$30,001 - \$40,000      \_\_\_\_\_ \$40,001 - \$50,000      \_\_\_\_\_ Over \$50,000

## INSURANCE INFORMATION

Type: Private \_\_\_\_\_ HMO \_\_\_\_\_ Medicaid \_\_\_\_\_ Medicare \_\_\_\_\_ State Agency \_\_\_\_\_ Other \_\_\_\_\_ None \_\_\_\_\_

Name of Company or Health Plan: \_\_\_\_\_ ID Number: \_\_\_\_\_

Name of HMO Physician: \_\_\_\_\_

(If this application is approved, further insurance information may be requested.)

## OFFICE USE ONLY

### MEDICAL DIRECTOR'S RECOMMENDATION

ACCEPT \_\_\_\_\_ REJECT \_\_\_\_\_ SCREEN \_\_\_\_\_

Reason for Rejection: \_\_\_\_\_

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_

### BOARD OF TRUSTEES ACTION

APPROVED \_\_\_\_\_ DENIED \_\_\_\_\_

Reason for Denial: Medical Financial Overage  
Non-Compliance Foreign Patient Policy

Signature \_\_\_\_\_ Date \_\_\_\_\_

## OFFICE USE ONLY

Return To: \_\_\_\_\_

Address: \_\_\_\_\_

Application Number: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

Date/Call/Received: \_\_\_\_\_ Date of Screening Visit: \_\_\_\_\_

Name of Person Initiating Form: \_\_\_\_\_