Children's Miracle Network Hospitals at St. Francis Health

Direct Family Assistance Guidelines

Who is eligible: Any child, aged 0 – 18, served at St. Francis Health or an affiliated clinic with a medical need. Children who receive funds through the direct family assistance program must be a patient of a St. Francis physician or receive care at St. Francis Health (past or present). Families should not exceed 300% of the current Federal Poverty Level. A poverty guideline chart can be found here: http://familiesusa.org/product/federal-poverty-guidelines

CMNH at St. Francis can provide funding in the following areas:

Prescription Assistance — This includes any prescription medication prescribed for your child (or specialized formula, oxygen supplement, etc.) that is not provided by another funding agency. Prescription assistance may be on a reimbursement basis or we can pay the pharmacy directly.
Developmental Therapy — Approved for funding on a case-by-case basis. These may include: horse, music, art, vision or other types of specialized therapy. Speech, physical, and occupational therapies are also considered in this area of funding.
Special Equipment — This includes glasses, wheelchairs and accessories, hearing aids, feeding tubes, orthotics (leg braces, remolding helmets, shoe inserts, etc.) and more.
Travel Assistance — we will be able to grant up to $500 a year for travel reimbursement to a patient that has been referred to a specialist outside of our realm of care. Proof of appointment/hospitalization must be submitted with receipts for reimbursement.

Please Note—CMNH at St. Francis DOES NOT PROVIDE FUNDING FOR:

- Hospital bills, Doctors Bills or Dental Bills
- Utility bills or hookups, phone bills or rent
- Groceries
- Diapers
- Car Seats
- Computers
- Any costs related to vehicle repairs or maintenance, even if you have car trouble on the way to or from your child's appointment.
- Special diet (unless prescribed by your physician)
- Children that are not born yet or over the age of 19.

Please contact Shaina Moravec at 785-295-8181 or Shaina.Moravec@sclhs.net with any questions or concerns.

Children's Miracle Network Hospitals
Helping Local Kids

St. Francis Children's Miracle Network
Shaina Moravec
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Application for Direct Family Assistance

*** Return this application along with a copy of your most recent Federal Income Tax return ***

Photo of Child is Optional but Appreciated!

Today's Date: ___________________________

Child's Name: ___________________________ Birthdate: ___________ Gender:__________

Applicant Information

Name of Person completing application: ____________________ Relationship to child:_______

Spouse / Co-Parent name: ____

Home Address:____

City:__________________ Zip Code: _______________ County: _______________________

Email Address: ____

Phone Number (home):_____________________ (work):__________________________

Applicant's Employer: _____________________ Occupation: ______________________

If unemployed, how long? _________________

Spouse's Employer: _______________________ Occupation: _____________________

If unemployed, how long? _________________

Total Number of Family Members: ___________ Ages of children: ______________________

Automobile (s): Make ________________ Model_____________ Year________

Make ________________ Model _____________ Year ________

Name, address and phone number of nearest relative not living with you:____________________

____

Relationship: ____

Financial Information

Monthly Income (Estimates)

(Total of both applicant and spouse)

a. Gross Salary (before taxes) $___________

b. Net Salary (after taxes) $___________

c. Social Security Income including SSI $___________

d. Unemployment Income $___________

e. Child Support $___________

f. Other $___________

Total (add lines b-f) $___________

Monthly Expenses (Estimates)

a. Rent/House Payment $___________

b. Car Loan(s) $___________

c. Other Bank Loan (specify type) $___________

d. Groceries (indicate if on food stamps) $___________

e. Utilities (electricity, gas, water, phone, etc.) $___________

f. Car expenses (gas, repairs, insurance) $___________

g. Health and/or Life Insurance $___________

h. Charge account(s) $___________

i. Other (please specify) $___________

Total (add lines a-i) $___________

Is your child receiving Kansas Medicaid benefits? YES/NO (Circle one)

Additional Information

Please be as specific as possible.

1. State the nature of the child's health problem(s). Briefly describe any treatment that has been provided at this point.

2. Name(s) of doctor(s) assisting with your case:

3. Please list St. Francis physician or clinic visited by the child/family

4. What plan of care has been recommended?

4. What assistance is being requested? $_________________

Please be specific about the dollar amount and type of assistance (medications, equipment, treatment, etc.). Please provide supporting documentation (i.e. prescription, invoice, letter from doctor or therapist etc.) Please advise if assistance from another organization is being received in conjunction with the possible CMN funding.

St. Francis Children's Miracle Network may contact me for publicity and/volunteering purposes. Please circle one. Yes No

How did you hear about Direct Family Assistance through Children's Miracle Network at St. Francis?

I acknowledge that the information I have given is true and correct.

____ ________________

Signature of Applicant/ Parent or Legal Guardian Date

____ ________________

Signature of Physician, Therapist or Hospital Associate Date

Children's Miracle Network Hospitals Consent Form

AUTHORIZATION FOR RELEASE OF INFORMATION AND/OR
PUBLIC USE OF IMAGE (PHOTOGRAPH OR VIDEO)

I hereby give my consent to participate in a promotional story, advertisement, and/or image (photograph, recording, and/or video) made for Children's Miracle Network in which I (or the person named below, for whom I am a legal guardian) will be interviewed and quoted by name. I am aware that this story, advertisement, and/or image (photograph, recording, or video) may appear in the public media including print, internet, and/or broadcast media for a period of up to ten years. I have been told that this story, advertisement, and/or image may be used more than once for promotional purposes by Children's Miracle Network Hospitals. I have been informed that my health care and the payment of my health care will not be affected if I do not sign this form.

____ ____________________
Patient Name (Please Print) Date

____________________________ _______________ _______ _______
Address City State Zip

__________________ ____________________ __________________________
Home Phone Work Phone Email

....

____ ____________________
Signature of Patient/Patient Representative Date

____ ____________________
Printed Name of Patient's Representative Patient's Birth Date

____
Relationship to Patient