## TO APPLY FOR FUNDING:

1. **Fill out the application completely and sign it.**
2. **Attach the most recent copy of your pay stub or W2.**
3. **Attach or fax a letter of need from the physician.**
4. **Families applying for assistance with hospital bills must have applied for Medicaid first, if you do not have insurance and are self-pay. The balance after Medicaid, if your child is eligible, will be considered for payment. The balance after the insurance company has paid will also be considered for payment.**

MAIL OR FAX COMPLETE APPLICATION TO:
**CHILDREN'S MIRACLE NETWORK**
**3525 S. NATIONAL, SUITE 203**
**SPRINGFIELD, MO 65807**

**If you are updating your file with a new application, you do not need a doctor's letter.**

Our hours of operation are Monday – Friday 8:30 AM to 5:00 PM
Phone: (417) 269-6853 Fax: (417) 269-8818

**CMN PROVIDES FUNDING FOR:**

*-Medical Equipment and supplies for dependent children birth through 18 years old*
*-Prescription medication that is not provided by any other agency*
*-Prosthesis / eye glasses / braces / wheelchairs / hearing aids*
*-Hospital bills, physical therapy, and speech therapy, if with the CoxHealth.*
*-Travel, lodging, and food for doctor's visits and hospital stays*

**CMN DOES NOT PAY:**

Doctor bills or dental bills
Utility bills or hookups
Any expense not directly related to the health care of a child

Any request must be considered **by a physician** to be an absolute medical necessity and must be confirmed in writing.

Application #:________

Disbursement Code:______

# Children's Miracle Network
# Application for Assistance

**PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY**

Date: _________________ County:__________________

Child's Name: __________________________________________________________ DOB: ______________________

Child's Social Security#:________________________________

Parents or Guardians Names:_______________________________________________________________________________

Child's Address:_________________________________________________________________________________________

City:________________________________State:_____________________________________ZipCode:________________

Daytime Phone: (_______)_____________________________Evening Phone: (_______)___ __________________________

Number of children in the home:______________________________Ages:__________________________________________

**All applications must be accompanied by a letter from the primary physician declaring the need for what is requested and verifying the illness or injury stated. Letters may be faxed to CMN. at (417) 269-8818.**

| | |
|---|---|
| What kind of assistance does your child require? | |
| Nature of child's illness or injury. | |
| Name of child's physician. | |
| Date(s) of hospitalization (if applicable). | |
| Cox Account Number. | |
| Do you have insurance? Yes or No | If yes, what company? |
| Do you have Medicaid? Yes or No<br>If no, have you applied? Yes or No | Medicaid Number: MO or AR |
| | |

**Families applying for assistance with hospital bills must have applied for Medicaid first, if you do not have insurance and are self-pay. The balance after Medicaid, if your child is eligible, will be considered for payment. The balance after the insurance company has paid will also be considered for payment.**

**PLEASE ATTACH A COPY OF YOUR MOST RECENT PAY STUB OR W2 FORM.**

CMN may seek a credit report to confirm any information disclosed. Income amounts should be reported ***after*** taxes.

Father or guardians Employer: ________________________________________ Phone: (______) ________________

Mother or guardians Employer: ________________________________________ Phone: (_____) _________________

If you are self-employed, please describe the nature of your business: ________________________________________

____________________________________________________________ Phone: (_____) ______________________

| Father or guardian's income (after taxes) **per month** | $ |
|---|---|
| Mother or guardian's income (after taxes) **per month** | $ |
| Additional income/overtime per month | $ |
| Child support received | $ |
| Business income per month after expenses | $ |
| Second job income | $ |

| Other income. Specify: | $ |
|---|---|
| Do you receive:<br>WIC?<br>Food Stamps?<br>Food Kitchen? | <br>Yes or No<br>Yes or No<br>Yes or No |
| Please specify other assistance received. | $ |

ASSETS: This is asking for current balances and current estimates of the value of property owned.

| Do you own your home? Yes or No | Mortgage Value: $ | Monthly Payment: $ | If trailer, monthly pad site cost? $ |
|---|---|---|---|
| Vehicle Information 1 | Type: | Year: | Monthly Payment: $ |
| Vehicle Information 2 | Type: | Year: | Monthly Payment: $ |
| Vehicle Information 3 | Type: | Year: | Monthly Payment: $ |
| Do you own rental property? Yes or No | Value of Property: $ | Monthly Payment: $ | Monthly Income: $ |
| Do you own a business? Yes or No | Nature of Business: | Monthly Expenses: $ | Monthly Income: $ |
| Do you own acreage? Yes or No | Number of Acres: | Value of Land: $ | Monthly Payment:: $ |
| Do you own livestock? Yes or No | Kind of Livestock: | Value of Livestock: $ | Monthly Payments: $ |

BANK ASSETS: Please list current balances or value of the following information.

| Cash on Hand | $ |
|---|---|
| Savings Account Balance | $ |
| Checking Account Balance | $ |
| Stocks/Bonds/IRA/ | $ |

| Trust | |
|---|---|
| Additional Assets. Type: | $ |

MONTHLY EXPENSES: **Please estimate the total amount spent per month by your entire household.**

| Rent | $ |
|---|---|
| Gas | $ |
| Phone | $ |
| Trash | $ |
| Life Insurance | $ |
| Child Care | $ |
| Child Support Paid | $ |

| Utilities | $ |
|---|---|
| Car Insurance | $ |
| Long Distance | $ |
| Medical Insurance | $ |
| Home/Other Insurance | $ |
| Cell Phone/Pager | $ |

| Other: | $ |
|---|---|

Other Monthly Payments

| Credit Card 1 | Type: | Monthly Payment: $ | Balance: $ |
|---|---|---|---|
| Credit Card 2 | Type: | Monthly Payment: $ | Balance: $ |
| Credit Card 3 | Type: | Monthly Payment: $ | Balance: $ |
| Credit Card 4 | Type: | Monthly Payment: $ | Balance: $ |
| Medical Expense 1 | For: | Monthly Payment: $ | Balance: $ |
| Medical Expense 2 | For: | Monthly Payment: $ | Balance: $ |
| Medical Expense 3 | For: | Monthly Payment: $ | Balance: $ |
| Medical Expense 4 | For: | Monthly Payment: $ | Balance: $ |
| Other Expenses, please be specify: | Finance Company: | Monthly Payment: $ | Balance: $ |

Additional information to assist with your application:

## <u>YOUR APPLICATION CANNOT BE PROCESSED WITHOUT THE FOLLOWING:</u>

1. The application **completely** filled out.
2. A letter of need from the physician.
3. A copy of your most recent pay stub or W2.

*The undersigned agrees to the truth of this information at the time of application. CMN reserves the right to review this information on an annual basis to consider any change in the status of these reported amounts.*

________________________________________ __________________________

Signature Date

Please mail or fax the application to: Children's Miracle Network
3525 S. National, Ste. 203
Springfield, MO 65807
Phone (417) 269-5437
Fax (417) 269-8818

**COXHEALTH**

**CHILD'S NAME:**_______________________________________________

**ALL APPLICANTS PLEASE READ AND SIGN BELOW:**

I waive and relinquish any and all claims or liabilities against CoxHealth,
Children's Miracle Network, and their employees or representatives. I guarantee the information in this request for funding to be accurate, complete, and true. I understand that altering this application or providing false information in any way will result in denial of this request.

I give Children's Miracle Network permission to contact any previous individuals and / or companies for references.

Signature of Parent / Guardian________________________________Date________

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

## PUBLICITY RELEASE
(OPTIONAL)

I agree to allow CoxHealth, the Children's Miracle Network, or any of its departments to:

_______Use my child's photograph and / or personal story.

_______Use my family's photograph and / or personal story.

If checked, either may be used for publicity purposes, including television, radio, booklets, newspaper, or magazine stories or advertisements.

Signature of Parent / Guardian________________________________Date__________