Children's Miracle Network Hospitals
Application for Assistance

Children's Miracle Network Hospitals at CoxHealth is pleased to be able to provide support for children (age birth to 18) in our designated service area through the following programs:

Travel Assistance: For appointments related to your child's medical care. To receive support, prior to the appointment you must have your physician or hospital send a confirmation letter of the appointment to the CMN Hospitals office. Travel assistance can only be used for fuel and hotel – no food or other expenses. If you are uninsured - to be considered for travel assistance, you must apply for Medicaid and provide an "Action Notice" within three months of requesting assistance.

CoxHealth Hospital & Therapy Bills: Children who receive treatment at CoxHealth may apply for assistance with inpatient and outpatient bills through our Family Care Grant. These applications are reviewed on a monthly basis. Bills that are already in collections are not eligible for support. Physician's bills or those from the following: Emergency Physicians of Springfield, Litton and Giddings Radiology, Cox Regional Services, Anesthesiologists, Orthopedic Associates of Springfield, or bills from any other hospital are not eligible for the CMN Family Care Grant.

Special Needs: CMN Hospitals considers applications for special needs items related to the child's medical condition that are not covered by any other source of insurance, federal or state aid or supporting program. Items can include medications, glasses, wheelchairs and accessories, hearing aids, feeding tubes, orthotics, remolding helmets, shoe inserts, and more. All requests must be prescribed by a doctor and have an accompanying letter confirming the need. CMN Hospitals is not able to support requests for handicap accessible vehicles, wheel chair ramps, bath lifts, therapeutic toys, or orthodontics of any kind.

CHECKLIST—HOW YOU CAN APPLY FOR FUNDING:

- □ Fill out the application **completely** and sign it.
- □ Attach the appropriate documentation for the assistance you are requesting. Confirmation of the request or referral from a physician is REQUIRED. No exceptions.
  You can have your doctor's office fax the confirmation to (417) 269-8818.
- □ Attach a copy of your most recent federal tax return. If you did not file a tax return, please explain why and submit a copy of your most recent W-2 or two most recent pay check stubs. **EXCEPTION:** Families requesting assistance for breast pump rental from The Women's Center **only** do not need to provide verification of income.
- □ To be considered for fuel funding, you must apply for Medicaid for your child and provide an "Action Notice" within three months of requesting assistance from CMN Hospitals. Additionally, if you are requesting funding for CoxHealth hospital bills and you are uninsured, you must first apply for Medicaid. If you are uninsured and do not qualify for Medicaid, you must then apply for financial assistance through the CoxHealth Patient Financial Services office. Bills that are in collections will not be considered.
- □ Return the application to the Children's Miracle Network Hospitals office. Applications are usually processed in 5-7 business days. Please **DO NOT** wait until the day before you require assistance to apply since we are not always able to process applications on a daily basis.

RETURN COMPLETED APPLICATION TO:
Children's Miracle Network Hospitals
3525 S. National Avenue, Suite 203
Springfield, MO 65807

Fax: (417) 269-8818
Phone: (417) 269-5437
Hours: Monday, Wednesday and Thursday
8:30 a.m. - Noon and 1:30 p.m. - 4:30p.m.

PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY

Application Date_____

Child's Name: _____ DOB: _____

Male _____ Female____

Parent(s) or Guardian(s) Name: _____

Child's Address: _____

City: _____ State: _____ Zip: _____

County:_____Daytime Phone: (___)_____ Evening Phone: (___)_____

Mother's Cell Phone: (____)_____ Father's Cell Phone: (____)_____

Email Address: _____

Number of Children in the Home: _____ Ages: _____

Have you ever applied for assistance from CMN Hospitals before? □Yes □No

What kind of assistance are you requesting from CMN? (Ex: travel, hospital bills, therapy bills, prescriptions, etc.)	
Nature of child's illness or injury.	
Name of child's physicians (primary care or out of town).	
Date(s) of hospitalization, if applicable.	
CoxHealth Account Number (if hospital bills).	
Do you have insurance? Yes or No	If yes, what company?
Do you have Medicaid for your child? □Yes □ No □Denied If Denied...Why? If No...Have you applied for Medicaid? □Yes □No	If yes, do you have □MISSOURI or □ARKANSAS Medicaid? If yes, do you pay a Medicaid premium □Yes □No Managed Care Plan? □No □MoCare □HomeStateHealth □UHC Medicaid #:

Father's employer: _____ Phone: (____)_____

Mother's employer: _____ Phone: (____)_____

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

_____ Phone: (____)_____

Fathers (net) monthly Income:$_____ Mother's (net) monthly income:$_____

Child Support received:$_____Other business income:$_____

Income received from any other source (please explain):$_____

All assets should consist of an estimate of the value of property or vehicles owned.

Please include estimates of current balances on investment or savings information.

Do you own your own home? □Yes □No	If yes, approximate value of home: $		
How many vehicles do you own?	Value of vehicle # 1:$	Value of vehicle # 2:$	Total value of vehicles:$
Do you own farm equipment, jet skis, motorcycles, or any other recreational or other equipment?	Value of farm equipment:$	Value of other equipment:$	
Retirement Funds/IRA/Pension:	Value of Retirement:$	Pension:$	Other:$
Do you have money in investments such as stocks, CD's, etc.	Value of Investments:$		
Do you own Rental Property? □Yes □No	Value of Property:$	Monthly Income from Rental Property:	$
Do you own land/acreage? □Yes □No	Value of Land:$	Number of acres:	
Do you own livestock? □Yes □No	Value of Livestock:$	Type of Livestock:	

Cash on Hand	$
Savings Account Balance	$
Checking Account Balance	$

Additional Assets:	
Type:	$
Type:	$

MONTHLY EXPENSES — Please Estimate Monthly Payments

Rent/House Payment	$	Child Care	$
Vehicle Payment	$	Gas for Vehicle(s)	$
Food/Household Expenses	$	Child Support Paid	$
Phone	$	Utilities	$
Insurance – Home (if not included in mortgage): Auto: Life (if not deducted from paycheck): Medical (if not deducted from paycheck):	$ $ $ $	Trash	$
		Internet	$
		Cable/Satellite Dish	$
Business expenses	$	Other (please list)	$

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 Expenses 1	For:	Monthly Payment$	Balance:$
Medical Expenses 2	For:	Monthly Payment$	Balance:$
Medical Expenses 3	For:	Monthly Payment$	Balance:$
Medical Expenses 4	For:	Monthly Payment$	Balance:$
Student Loans	For:	Monthly Payment$	Balance:$
Other Expenses (Please be Specific)	Finance Company:	Monthly Payment$	Balance:$

Children's Miracle Network Hospitals is a charity designed to help families that have children age birth through 18 years of age with medical expenses not covered by insurance or Medicaid. Please list any additional information that would help us understand your needs.

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ALL APPLICANTS PLEASE READ AND SIGN BELOW

I guarantee that the information in this request for funding is accurate, complete and true. I understand that altering this application or providing false information in any way will result in denial of this request By signing this application, I give Children's Miracle Network Hospitals at CoxHealth authorization to obtain and verify any financial information on this application, including but not limited to medical bills, rent payments, and credit card bills; to contact any individuals or companies listed on this application for any purpose related to this application; and to otherwise verify, as necessary, any other information I have listed herein. I understand that a confirmation of my child's need from a physician must accompany this application. I understand applications may take 5-7 business days to process, or up to 30 days for Family Care Grant requests (CoxHealth hospital & therapy bills).

( ) I give my permission to CMN Hospitals to utilize my child's story to support the mission and cause of CMNH through all forms/types of media not limited to include broadcast, print, electronic (i.e. social media) and radio.

Signature of Parent/Guardian_____ Date _____