Aladdin Shriners

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: _____

1801 Gateway Circle, Grove City, Ohio 43123
(614) 475-2609 www.aladdinshrine.org

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: _____

HOW CAN WE HELP?

What assistance are you looking for from the ASHAC program?
_____
_____

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: _____