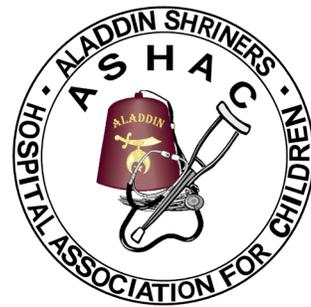


# Hospital Association for Children



## ASHAC PROGRAM APPLICATION

### CHILD'S INFORMATION

PATIENT NUMBER: \_\_\_\_\_

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

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

County of Residence: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_

Phone: \_\_\_\_\_ Who does the child live with primarily? \_\_\_\_\_

### MOTHER'S INFORMATION

Check if same address as child.

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

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

Email: \_\_\_\_\_ Marital Status: \_\_\_\_\_

### FATHER'S INFORMATION

Check if same address as child.

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

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

Email: \_\_\_\_\_ Marital Status: \_\_\_\_\_

### LEGAL GUARDIAN

Check if same address as child.

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

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

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

### SPONSORING SHRINER INFORMATION

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

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

Phone: \_\_\_\_\_ Signature: \_\_\_\_\_

**NOTE:** All applications will be reviewed by the ASHAC Board of Trustees. A letter with the Board's decision will be sent after the application has been reviewed. Services that were prior to acceptance will not be eligible for coverage.

**MEDICAL INFORMATION**

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

Describe Chief Complaint/Symptoms: \_\_\_\_\_

\_\_\_\_\_

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

Is this problem due to an injury? \_\_\_\_\_ If yes, what was the date of injury? \_\_\_\_\_

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

**Previous Treatment:**

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

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

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

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

**Treatment Provided:**

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

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

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 a Shriners Hospital? \_\_\_\_\_

If yes, when? \_\_\_\_\_ which location? \_\_\_\_\_

**HOW CAN WE HELP?** What assistance are you looking for from the ASHAC program?

\_\_\_\_\_

\_\_\_\_\_

**INSURANCE INFORMATION**

Does the applicant have health insurance? \_\_\_\_\_

If yes, what type: Private Medicaid BCMHS Other

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** -----

Evaluation Requested: \_\_\_\_\_

Application Accepted - Effective Date: \_\_\_\_\_

Application Denied – Reason: \_\_\_\_\_

Medical Director’s Signature: \_\_\_\_\_ Parents notified of decision: \_\_\_\_\_