Aladdin Shriners

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 ☐ BCMH ☐ 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: _____