Aladdin Shriners

Hospital Association

for Children

ASHAC PROGRAM APPLICATION

CHILD'S INFORMATION

PATIENT ID: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____ County: _____

Birthdate: _____ Sex: ☐ Male ☐ Female

MOTHER'S INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Email: _____ Phone: _____ Marital Status: _____

FATHER'S INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Email: _____ Phone: _____ Marital Status: _____

LEGAL GUARDIAN

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Email: _____ Phone: _____ Relationship to Child: _____

SPONSORING SHRINER INFORMATION

Last Name: _____ First Name: _____ Member Number: _____

Address: _____

City, State, Zip: _____

Email: _____ Phone: _____ Signature: _____

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? _____

Previous Treatment:

Physician: _____ Hospital: _____

Full 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 at 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 ☐ CMH ☐ Other: _____

Name of Company or Health Plan: _____ ID Number: _____

(If this application is approved, further insurance information may be requested.)

All applications are reviewed by the ASHAC Board of Trustees. Applicants will be notified of the Board's decision once the review process is complete. Please note that services received prior to acceptance into the program are not eligible for coverage. Pre-authorizations are required for most services.

Applications may be submitted through our website, by email to ashac@aladdinshrine.org, by fax to 614-991-6457, or by mail. If you have questions about the program or would like to discuss how we may be able to assist you, please call (614) 269-0240.

SUBMIT