APPLICATION FOR TREATMENT
SHRINERS HOSPITALS FOR CHILDREN

***Required Information**

To Be Completed By Parent or Guardian

***Name of Child**			
*Last	*First	Middle	Suffix
*Application Date (Today's Date)	Child's SSN	*Gender ☐ Male ☐ Female ☐ Other ☐ Unknown	
*DOB	Who does child live with? ☐ Both Parents ☐ Mother ☐ Father ☐ Other (relationship) _____		
Primary Language	Interpreter Required ☐ Yes ☐ No		
***Home Address**			
*Country	*Street Address		
*Zip Code	*City	*State	County
Phone Primary /Home Number	Phone Alternate Number		
***Mailing Address (if different from home address)**			
*Country	*Street Address		
*Zip Code	*City	*State	County

Mother				
Last	First	Middle	Suffix	Maiden Name
Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Separated				
Home Address (if different from patients)				
*Country	*Street Address			
*Zip Code	*City	*State	County	
Phone Primary /Home Number	Phone Alternate Number			

Father			
Last	First	Middle	Suffix
Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Separated			
Home Address (if different from patients)			
*Country	*Street Address		
*Zip Code	*City	*State	County
Phone Primary /Home Number	Phone Alternate Number		

Additional Relations			
Relationship to Patient			
Last	First	Middle	Suffix
Home Address (if different from patients)			
*Country	*Street Address		
*Zip Code	*City	*State	County
Phone Primary /Home Number	Phone Alternate Number		

APPLICATION FOR TREATMENT
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*Required Information

Name of Child **To Be Completed By Parent or Guardian**

Legal Guardian (if different from parent)

Last	First	Middle	Suffix

Home Address (if different from patients)

*Country	*Street Address		
*Zip Code	*City	*State	County
Phone Primary /Home Number	Phone Alternate Number		

Sponsoring Temple and Shriner

Temple				
Sponsoring Shriner Name	Last	First	Sponsor signature date	
Street Address	City	State	Zip Code	Country
Sponsoring Shriners Signature				
Needs Transportation ☐ Yes ☐ No	Ambulatory Status			

Medical

*Problem or Diagnosis
(What is your child's problem?)

Onset ☐ Before Birth ☐ Developed Recently ☐ Injury-Date Known Injury date _____
☐ Injury-Date Unknown ☐ Onset of walking ☐ Since Birth Other

Chief Complaint (Why do you want to be seen by the Shrine Hospital? What services are you looking for?)

Referring Physician

Street Address	City	State	Zip Code	Country

Previous treatments provided

Treatments and Surgeries

X-rays available? ☐ Yes ☐ No	Date of Most Recent X-ray	Date Last Seen by Physician

Insurance/Primary

Subscriber Name

Health Plan

Name	Subscriber Member Number	Patient Member Number

Primary Care Provider

Supplemental Information

Referral Source (Select One)

☐ Billboard ☐ Bumper Sticker ☐ Family Member/Self ☐ Newspaper ☐ Unknown ☐ Other
☐ Poster/Flyer ☐ Physician ☐ Other Health Care Professional ☐ School Teacher ☐ School ☐ Radio
☐ Shriner ☐ Television ☐ Friend (non-Shriner) ☐ Watts Line ☐ Website

Family Income for 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 ☐ Not provided

APPLICATION FOR TREATMENT
SHRINERS HOSPITALS FOR CHILDREN

***Required Information**

Name of Child ____________________

FOR HOSPITAL USE ONLY

Application Status				
COS Recommendation	☐ Accept	☐ Reject	☐ Screen	Date of Recommendation
COS Comments				
BOG Recommendation	☐ Application Expired	☐ Approved	☐ Denied	Date of Recommendation
Primary Shrine Physician		Care Coordinator		
COS Signature				
BOG Signature				
Service Line	☐ Ortho	☐ Burn	☐ SCI	☐ Plastic
Over Age Patient	☐ Yes	☐ No		
Expedite (indicate specific timeframe if applicable)				

SHRINERS HOSPITALS FOR CHILDREN

CONDITIONS FOR ACCEPTANCE

Name of Child: ____

If accepted, the parents/legal guardians agree:

1. The undersigned certifies that the information supplied to Shriners Hospitals for Children is true and complete to the best of my/our knowledge. By signing below, I/we certify that I am/we are the natural or adoptive parents or legal guardian of the child named above, and that I am/we are legally authorized to consent to the medical care of the child. I/we agree to notify the hospital if there is any future change in this relationship.
2. I/we authorize such hospital care encompassing laboratory, diagnostic, and medical treatment including outpatient care, as the Chief of Staff or his assistants or designees shall, in their judgement, deem necessary.
3. I/we may be asked to consent to the use or transfusion of blood and blood products for my child if deemed necessary. I/we have the right to withhold this consent. If I/we withhold consent, I/we agree that my child's physician in his or her sole discretion, having deemed the use of transfusion of blood and blood products necessary, may discharge my child from the hospital so that I/we can make arrangements for treatment at another hospital of my/our choice.
4. The child's health information may be used by Shriners Hospitals for Children for treatment of the child; for payment of outside services' and for hospital operations.
5. In addition, I/we may be asked to authorize the use of the child's health information for scientific and educational purposes. The information used may include the nature of the child's medical conditions, operations, or procedures performed and the results, the results of diagnostic studies, x-rays, films and photographs. I/we understand that Shriners Hospitals for Children will use its best efforts to ensure that the child's identity is not revealed unless I/we specifically authorize the identification of the child in writing.

______________________________	______________________________
Witnessed by:	Signature of father or legal guardian:
______________________________	______________________________
Relationship to child:	Signature of mother or legal guardian
______________________________	______________________________
Date:	Signature of patient (If 14 years or older)

GUIDELINES FOR COMPLETION OF

SHRINERS HOSPITALS APPLICATION FORM FOR CHILDREN

The following information is required to complete the application for acceptance into a Shrine Hospital for Children.

1. Parents or guardians are to complete the first and second pages of the application.
2. The conditions of Acceptance form is to be **signed and witnessed**.
3. A copy of a STATE issued birth certificate is required, unless the child is less than six months of age. Certification issued by the hospital **is not** acceptable.
4. A copy of the child's immunization is required.
5. Submit the above four items to:

   Hospital Committee
   Ararat Shrine
   5100 Ararat Drive
   Kansas City, MO 64129

6. The Ararat Hospital Committee will forward the application and required documents to the appropriate hospital. After a review of the completed application by the hospital staff, the applicant is either accepted or rejected. In case of acceptance, the parent and guardian will be advised by the hospital staff as to the date and time of the first hospital visit. In case the applicant cannot be accepted, the Shrine Center is also notified.
7. In addition to providing the above documents, the parent or guardian may be asked to provide supplemental information at the time of their outpatient visit to the hospital.
8. You may call the Ararat Hospital Committee office with any questions: 816.923.1319.