



# IMPORTANT!!!



## YOU MUST READ THIS BEFORE COMPLETING THIS APPLICATION

### CMN CAN PROVIDE FUNDING ONLY IN THESE AREAS:

- **Travel Assistance:** For out-of-town appointments. A confirmation from the doctor's office of the appointment MUST be provided to CMN before any assistance is received. This money is to be used ONLY for travel (gas and lodging). The money may not be used for food, alcohol, tobacco, clothing, vehicle maintenance or diapers.
- **CoxHealth Hospital Bills:** These are only bills through CoxHealth. We CANNOT pay bills for Cox Professional Collections, Emergency Physicians of Springfield, Litton and Giddings Radiology, Cox Regional Services, Anesthesiologists, Orthopedic Associates of Springfield, or bills from any other hospital. (NO DOCTOR OR DENTAL BILLS OF ANY KIND CAN BE PAID)
- **CoxHealth Therapy Bills:** These are only bills through CoxHealth for physical, occupational or speech therapies. We CANNOT pay bills for any other kind of therapy by any other therapy provider or independent physician providing any kind of special therapy.
- **Special Equipment:** This includes glasses, wheelchairs and accessories, hearing aids, feeding tubes, orthotics (leg braces, remolding helmets, shoe inserts, etc), and more. Equipment MUST be prescribed by a doctor. This does not include cars, handicap accessible vehicles, wheel chair ramps, bath lifts, therapeutic toys, or orthodontics of any kind. Contact Children's Miracle Network for more information.
- **Prescription Medication:** This includes any prescription medication prescribed for your child that is not provided by another agency. You MUST turn in a copy of the prescription when applying for assistance with medication. If you are applying for reimbursement for medication, you must provide receipts from the pharmacy with your child's name on them showing proof of payment.
- **Synagis Shots:** CMN can only pay for synagis shots if they are needed for RSV prevention ONLY if prescribed by a doctor and ONLY through Cox Home Parental Services.

**All requests must be considered a medical necessity by a physician and must be confirmed in writing.**



### CMN DOES NOT PROVIDE FUNDING FOR:



- Horse, Music, Art, Vision or any other kind of specialized therapy
- Special Clothing or Bedding
- Therapeutic Toys
- Doctors Bills or Dental Bills
- Utility Bills or hookups, Phone Bills or Rent
- Groceries
- Diapers
- ANY costs to fix/maintain your car, even if you have car trouble on the way to or from your child's appointment.
- Car Seats
- Computers
- Special Diets (unless prescribed by a doctors if child cannot eat regular food for medical reasons).
- CoxHealth hospital bills that are in collections, even if they are in Cox Professional Collections.
- Children that are not born yet or over the age of 19.
- Any expenses that are not directly related to the health care of the child or are not deemed medically necessary.

Yes, I have read and agree to the above outlined rules and wish to apply for assistance from CMN.

SIGN HERE \_\_\_\_\_ DATE: \_\_\_\_\_

## CHECKLIST—HOW YOU CAN APPLY FOR FUNDING:

- Fill out the application **completely** and sign it.
- Attach a letter from your child's doctor stating your child's diagnosis and the need for assistance requested.
- Attach the appropriate documentation for the assistance you are requesting:
  - For Prescription Medication: attach a copy of the prescription from the doctor
  - For Travel Assistance: attach a confirmation of your child's appointment. (You can also have your doctor's office fax one to us at 417-269-8818.
  - For Special Equipment, Diet, Supplements, Etc: attach a letter from your child's doctor stating medical necessity. The letter must state that the equipment, diet, supplements, etc. is **medically necessary** for your child's health. **IT MUST BE PRESCRIBED.**
- Attach the most recent copy of your pay stub or W2.
- Families that do not have insurance, or are self-pay and are applying for assistance with hospital or therapy bills **must apply for Medicaid before assistance is rendered.**
- Only the balance after Medicaid or other insurance payment will be considered for funding. **Bills that are in collections, even Cox Professional Collections will not be considered.**
- Once the application is completed, please return it to the Children's Miracle Network office.

## IMPORTANT INFORMATION:

If you are updating a previous application, you **do not** need a new doctor's letter.

If you are requesting assistance for something different than your previous application, you **do** need a new doctor's letter or prescription.

If you are a foster parent applying for a foster child, disregard income questions and next to your name on the first page please write that you are the foster parent.

The Children's Miracle Network Telethon Year fiscal year runs June 1st thru May 31st each year.

**All assistance is based on the current funding available.**

### RETURN COMPLETED APPLICATION TO:

Children's Miracle Network  
3525 S. National Ave. Suite 203  
Springfield, MO 65807

Fax: 417-269-8818

### CMN OFFICE HOURS:

Monday—Friday: 8:30 am—5:00 pm  
Saturday and Sunday: CLOSED

Phone: 417-269-6853  
Fax: 417-269-8818



# Children's Miracle Network Application for Assistance

Telethon Year \_\_\_\_\_

Limit \_\_\_\_\_

**PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY**

APPLICATION DATE: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Please Circle One: Male Female

Parent(s) or Guardian(s) Name: \_\_\_\_\_

Child's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Daytime Phone: (\_\_\_\_) \_\_\_\_\_ Evening Phone: (\_\_\_\_) \_\_\_\_\_

Mother's Cell Phone: (\_\_\_\_) \_\_\_\_\_ Father's Cell Phone: (\_\_\_\_) \_\_\_\_\_

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

Number of Children in the Home: \_\_\_\_\_ Names and Ages: \_\_\_\_\_

Have you ever applied for assistance from Children's Miracle Network before? \_\_\_\_\_ When? \_\_\_\_\_

**All applicants must be accompanied by a letter from the primary care physician declaring the need for what is requested and verifying the illness or injury stated. If assistance is needed for travel expenses for an appointment out of town, then a confirmation of appointment from the out of town physician must be provided to Children's Miracle Network PRIOR to the appointment. (NO EXCEPTIONS!)**

What kind of assistance are you requesting from CMN? (Ex: travel, hospital bills, therapy bills, prescriptions, etc.)	
Nature of child's illness or injury.	
Name of child's physicians (primary care or out of town).	
Date(s) of hospitalization, if applicable.	
CoxHealth Account Number (if hospital bills).	
Do you have insurance? Yes or No	If yes, what company?
Do you have Medicaid? Yes or No or Denied If Denied...Why? If No...Have you applied for Medicaid? Yes or No	If yes, do you have MISSOURI or ARKANSAS Medicaid?  Medicaid #:

**TO FAMILIES APPLYING FOR ASSISTANCE WITH  
COXHEALTH HOSPITAL OR THERAPY BILLS:**

Families applying for assistance with CoxHealth hospital bills that do not have insurance, must apply for Medicaid AND the CoxHealth Patient Financial Assistance Program before receiving assistance through Children's Miracle Network. If you are eligible for assistance, the balance **after** insurance or Medicaid has paid will be considered for payment.

***Eligibility does not ensure payment. Talk with the Director of Children's Services for more information about bills.***

**CMN DOES NOT PAY:**

- Hospital Bills that have been sent to a collection agency. This includes Cox Professional Collections. (NO EXCEPTIONS!)
- Any doctor's bills of any kind.
- Any hospital bills other than CoxHealth.
- Bills from other health organizations, including but not limited to Cox Regional Services, Litton and Giddings Radiology, Orthopedic Associates of Springfield, Emergency Physicians of Springfield, or anesthesiologist bills..

CMN may seek a credit report to confirm any information disclosed.

Father's employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Mother's employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

If you are self-employed, please describe the nature of your business: \_\_\_\_\_

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### INCOME AND OTHER ASSETS

All income should be reported as your **net** income (**AFTER TAXES**). Please indicate your **monthly** income only.

Father's <b>monthly</b> income (after taxes)	\$	Other <b>monthly</b> income	\$
Mother's <b>monthly</b> income (after taxes)	\$	SSI <b>monthly</b> incomes	\$
Additional income/overtime per month	\$	Do you receive:	
Child support received <b>monthly</b>	\$	WIC?	Yes or No
Business income per month after expenses	\$	Food Stamps?	Yes or No
<b>Monthly</b> Second job income	\$	Food Kitchen?	Yes or No
		Please specify any other assistance your family receives (this includes other charitable assistance).	

All assets should consist of an estimate of the value of property or vehicles owned. Please include estimates of current balances on investment or savings information.

Do you own your own home? Yes or No	If yes, approximate value of home: \$		
How many vehicles do you own?	Value of vehicle # 1: \$	Value of vehicle # 2: \$	Total value of vehicles: \$
Do you own farm equipment, jet ski's, motorcycles, or any other recreational	Value of farm equipment: \$	Value of other equipment: \$	
Retirement	Value of Retirement: \$	Is there a penalty if you use your retirement early? Yes or No	How much of a penalty?
Do you have money invested in stocks, CD's or IRA's?	Value of Investments: \$	Is there a penalty for cashing out any of your investments? Yes or No	How much of a penalty?
Do you own Rental Property? Yes or No	Value of Property: \$	Monthly Income from Rental Property:	\$
Do you own land/acreage? Yes or No	Value of Land: \$	Number of acres:	
Do you own livestock? Yes or No	Value of Livestock: \$	Type of Livestock:	

Cash on Hand	\$	Additional Assets: Type: \$ Type: \$
Savings Account Balance	\$	
Checking Account Balance	\$	

FOR OFFICE USE ONLY—DO NOT WRITE BELOW DOTTED LINE TOTAL MONTHLY INCOME: \_\_\_\_\_ TOTAL ASSETS: \_\_\_\_\_

## MONTHLY EXPENSES — Please Estimate Monthly Payments

Rent/House Payment	\$	Child Care	\$
If Trailer- <b>monthly</b> pad site cost	\$	Child Support Paid	\$
If you own rental property: <b>monthly</b> payment	\$	Utilities	\$
If you own land/acreage: <b>monthly</b> payment	\$	Trash	\$
If you own your own business – related <b>monthly</b> expenses	\$	Cable/Satellite Dish	\$
If you own livestock: <b>monthly</b> payment	\$	Internet	\$
Vehicle Payment(s)	\$	Life Insurance	\$
Gas for Vehicle(s)	\$	Car Insurance	\$
Payment on farm equipment or any recreational equipment	\$	Medical Insurance	\$
Phone	\$	Home/Other Insurance	\$
Cell Phone/Pager	\$	Groceries	\$
Long Distance	\$	Other	\$

## OTHER MONTHLY PAYMENTS — Include Medical Expenses for Entire Family

Credit Card 1	Type:	Monthly Payment \$	Balance: \$
Credit Card 2	Type:	Monthly Payment \$	Balance: \$
Credit Card 3	Type:	Monthly Payment \$	Balance: \$
Credit Card 4	Type:	Monthly Payment \$	Balance: \$
Medical Expenses 1	For:	Monthly Payment \$	Balance: \$
Medical Expenses 2	For:	Monthly Payment \$	Balance: \$
Medical Expenses 3	For:	Monthly Payment \$	Balance: \$
Medical Expenses 4	For:	Monthly Payment \$	Balance: \$
Student Loans	For:	Monthly Payment \$	Balance: \$
Other Expenses, please be specific	Finance Company:	Monthly Payment \$	Balance: \$

**FOR OFFICE USE ONLY-DO NOT WRITE IN THIS BOX**

Total income from Page 3-\$\_\_\_\_\_

Total Asset Value from Page 3-\$\_\_\_\_\_

Total Expenses from Page 4-\$\_\_\_\_\_

**Total Income After Expenses**\_\_\_\_\_

Children's Miracle Network is a charity designed to help families that have children age birth through 18 years of age with medical expenses not covered by insurance or Medicaid. Please list any additional information that would help us understand your needs.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALL APPLICANTS PLEASE READ AND SIGN BELOW**

Child's Name:\_\_\_\_\_

I waive and relinquish any and all claims or liabilities against CoxHealth, Children's Miracle Network, and their employees or representatives. **I guarantee that the information in this request for funding to be accurate, complete and true. I understand that altering this application or providing false information in any way will result in denial of this request.**

**I give Children's Miracle Network permission to contact any previous individuals and/or companies for references.**

Signature of Parent/Guardian\_\_\_\_\_ Date\_\_\_\_\_

**OPTIONAL PUBLICITY RELEASE**

I agree to allow CoxHealth, Children's Miracle Network, or any of its departments to:

\_\_\_\_\_ Use my child's photograph or personal story.

\_\_\_\_\_ Use my family's photograph or personal story.

If checked, either may be used for publicity purposes including television, radio, brochures, donor publications, newspaper, magazine stories, fundraising events, educational purposes or advertisements. However, we do not promise or guarantee that your child will be used in any or all of the above.

Signature of Parent/Guardian\_\_\_\_\_ Date\_\_\_\_\_

**Please return completed application to:**

Children's Miracle Network  
3525 S. National Suite. 203  
Springfield, MO 65807

Phone: 417-269-6853  
Fax: 417-269-8818

## Fill This Portion Out Only If Applying for Equipment

Please include 3 price quotes for any equipment and a prescription for the equipment from your child's physician. Equipment will be approved or denied on a case by case basis. All equipment approved has to be medically necessary for that child to live or get better.

Child's Diagnosis \_\_\_\_\_

What piece of equipment are you requesting \_\_\_\_\_

Lowest Price Quote \$ \_\_\_\_\_ How long will your child use this equipment \_\_\_\_\_

Why is it necessary for your child to have it \_\_\_\_\_

## Fill This Portion Out Only If Applying for Special Diet Including Vitamins and Supplements

All approved special diets have to be medically necessary and prescribed by your child's physician.

Child's Diagnosis \_\_\_\_\_

What kind of diet are you requesting assistance with \_\_\_\_\_

What is the cost of this diet over normal costs for feeding your child? \_\_\_\_\_

How long will your child need to be on this diet \_\_\_\_\_

Why is it necessary for your child to have it? \_\_\_\_\_

**Make sure you've attached the prescription from the physician.**

## Fill This Portion Out Only If Applying for Medical Supplies

Child's Diagnosis \_\_\_\_\_

What kind of supplies are you requesting assistance with \_\_\_\_\_

How much will this cost per month? \$ \_\_\_\_\_

How long will your child need these supplies? \_\_\_\_\_

**Make sure you've attached a prescription from the physician.**



# Application Checklist

**Please make sure that the following items are included with this application**

**For all applications...**

- Either a check stub, a W2 or last year's income tax return must be attached to verify income.
- A doctor's letter stating diagnosis and the need to assistance requested.

**If you are applying for special equipment, prescriptions, hospital or therapy bills...**

- A Medicaid denial or acceptance letter must be attached.
- If applying for assistance with CoxHealth hospital bills or CoxHealth therapy bills, and you have no insurance of Medicaid, you must first apply for Cox Patient Financial Assistance.
- If applying for prescription medication or equipment, a copy of the prescription must be attached.
- If applying for special equipment, please attach at least 3 price quotes for the item(s) requested.

**If applying for travel assistance...**

- A verification of the appointment must be attached (Dr.'s can fax us confirmation at 417-269-8818) PRIOR to the appointment. NO EXCEPTIONS!!!

**Please note: Failure to provide the necessary documentation and paperwork related to assistance requested may result in delay in processing your application or receiving assistance. The required documents must be on file with the Children's Miracle Network office before assistance is given.**