Healing the Children®

Phone 407-877-9311/Fax: 321-247-5347

PO Box 608432 Orlando FL 32860 Tax ID: 59-3503974

Completed applications must include:

- Fully completed program application
- If a referral is coming from a local clinic, hospital, school, doctor's office, social worker or any other health professional and local program referral form must be submitted by referring entity.
- Photos: We request one photograph of child's affected area, it is a visible medical condition. Also please provide a photo of your child; a school photo or passport photo would be sufficient.
- A completed medical authorization form
- A completed medical release form
- Completed section of publicity form
- Proof of income (W4, or tax return or, letter from employer)
    - If unable to provide these documents, please provide us with a letter explaining your situation.
- Please list your monthly expenses (we may request copies of your monthly bill statements)
- If you have applied for CHIP (Healthy Kids/Medicaid) and have been denied, please provide us with letter of denial.
- Yearly application Fee (See last page of application)

Although we would like to help all children that need assistance with medical treatment, services are dependent on funds available and medical professional who are able to donate their services. Acceptance into our program is based on financial need, for children what do not qualify for insurance or are under insured. Parents are required to disclose full financial status in the application**. If we are not able to contact you within a 30 day period your case will be closed. Please contact us with any question or concern. We are here to help.**

ALL INFORMATION PROVIDED IS KEPT CONFIDENTAL. INFORMATION RELEASED FOR MEDICAL PURPOSES AND TREATMENT ONLY.

Much like our International Inbound Program, doctors, nurses and hospitals donate their faculties and expertise in order assist children eligible for our program.

Eligibility requirements:

- An application must be completed in full submitted to Healing the Children to be reviewed. Once the application is submitted in full it will be referred for placement.
- Children birth to 18 years old are eligible
- US Citizens, residence and non-residence are eligible
- Children must live within our graphic locations (Florida or Georgia).

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Due to our limited resources, we generally are not able to accept applications from children with terminal medical problems. For examples stem cell, bone marrow transplants, most cancers and organ transplants except skin or cornea. If HTC is not able to assist you we will make attempts to provide you with referrals to partner agencies and foundations that may be able to provide the necessary assistance.

Responsibility of client upon acceptance into the program:

- **All changes in financial income, insurance, address phone number or status of any kind need to be reported to us immediately.**
- **It is the client's responsibility to find transportation to and from appointments. However, when funding is available HTC will provide support to assist in transportation.**
- **The client is required to keep scheduled appointments if they cancel or fail to show schedule appointments without reason they may become ineligible for further assistance.**
- **It is required that 24-hour notice be given if you cannot make scheduled appointment.**
- **It is required that the client get permission from HTC to make appointments with a doctor's office for the child. Once initial appointment is made follow up appointments may be made by client, however Healing the Children most receive notice of scheduled appointment time and date.**
- **If MRIs, X rays, surgery or additional support should be coordinated through Healing the Children. Please contact us if the physician orders additional procedures, exams, or medications.**
- **In an emergency a child may be brought to the local emergency room to be treated by the hospital when the hospital bills for services received by the client the original copy must be submitted to HTC. HTC will make every attempt to advocate for a child by approaching the billing department about waiving fees. Please note: We cannot advocate on your behalf once bill have been sent to collection.**
- **All applications are good for one year. Upon completion of a year a new application must be submitted.**

PLEASE KEEP THE FIRST 2 PAGES FOR YOUR RECORDS.

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Personal Information:

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

Sex: M ☐ F ☐ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Cell: _____ Email: _____

Referred by: _____

Medical Information:

Medical Diagnosis: _____

Primary Doctor/Pediatrician: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Specialty Doctor:

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Parent/Guardian Information:

Does client live with both parents? Yes ☐ No ☐

Mother's Name: _____

Employer: _____

Employers Address: _____

Father's Name: _____

Employer: _____

Employers Address: _____

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Financial Information:

Total Monthly Income (Proof of Income is Required): $ _____

Total Monthly Expenses (Rent, Utility Bills, Car Payments, etc.): $ _____

Number of individuals in household: _____

Applications will not be processed unless we receive this information. HTC reserves that right to request copies of all monthly expenses. If a request for a copy of monthly expenses is made client must provide copies of said expenses to receive services within 30 days of request.

Have you applied for State Funded Insurance? Yes ☐ No ☐

If yes, when? _____

What was outcome? Accepted ☐ Refused ☐

Reason for refusal? (Please provide letter from State) _____

Please Mail Completed Application to:

Healing the Children

PO Box 608432

Orlando, FL 32860

You will be notified when your application is accepted and approved. Please do not hesitate to contact us with any questions or concerns. If you need help completing the application, please inform our office. We are here to help!

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RELEASE OF LIABILITY:

1. That I, _____ am the legal guardian or parent of

   _____ (child).

2. This consent is valid starting _____ and expires _____ .

3. Healing the Children and their physicians, volunteers, and employees will strive for the most positive outcome possible. However, I understand that no guarantees have been given and neither Healing the Children, physicians, its volunteers nor employees will be held responsible for any unforeseen complications or negative outcomes including the death of the patient.

   Signature: _____ **Date:** _____

4. PHOTO RELEASE: I do hereby give healing the children it assigned licensees and their legal representatives irrevocable right to use my child's name picture ,portrait, image video or photograph in all forms and media in all matters include composite, for advertising, republication or any other lawful purposes and waive any right to inspect or approve the finished products including written copy which may be created in connection therewith.

Signature _____ **Date:** _____

Printed Name: _____

Witness: _____

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Patient Name: _____

DOB: _____

Dear _____ :

This letter will authorize you to write a copy, summary or narrative above and read the record as indicated by the checkmarks below as otherwise released confidential information. At this time I am requesting the following:

___ Complete medical record

___ Records of care form _____ to _____only.

___ Records of care concerning the following condition(s): _____

_____

_____

___ Other, Please Specify _____

HIV/AIDS

I consent to the release of a positive or negative result for AIDS or HIV Infection, antibodies to AIDS, or infection with causative agent of AIDS with rest of my records.

Initials _____ Date: _____

Release of information to Healing the Children FL-GA inc.

Initials _____ Date: _____

Signature_____ **Date:**_____

Printed Name: _____