PO Box 608432 Orlando FL 32860 Phone 407-877-9311/Fax: 321-247-5347

Tax ID: 59-3503974

ANCILLARY SUPPORT APPLICATION.

Completed applications must include:

Fully completed program application most include:

- Referral for medical professional for ancillary support.
- 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) o 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.
- If you have insurance, but your insurance does not cover ancillary support needed please provide us with letter of denial of support.
- Applications are good for 3 months. If further support is needed, you will need to reapply.

Although we would like to help all children that need assistance, services are dependent on funds available.

We accept a limited number of new patients a year. 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 14-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.

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)

. 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 patient 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 patient's family's responsibility to find transportation to and from appointments. However, when funding is available HTC will provide support to assist in transportation.

- The patient 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.

    - Please note: Healing the Children will provide the patient with test results/notes from visits upon the parent's request. It will be the parent's responsibility to provide any providers that are not members/partners of Healing the Children with those records directly.

ALL APPLICATIONS ARE GOOD FOR 3 MONTHS. PLEASE RETAIN THESE FIRST 2 PAGES FOR YOUR RECORDS.

Domestic Aid Program: Ancillary Support Application

Child's Last Name:_____ First Name:_____

DOB:_____ Guardian/Parent's phone number:_____

Address:_____

Parent/Guardian's Email:_____

Name of Medical Professional Ordering Support: _____

Phone number:_____ Fax number:_____

Address:_____

Type of Ancillary support needed: _____

Medical diagnosis:_____

Parent/Guardian Information: Does patient live with both parents? Yes ___No___

Guardian/Mother's Name:_____

Employer_____

Employers Address:_____

Guardian/Father's Name: _____

Employer: _____

Employers Address: _____

If you are not currently employed, please submit a letter stating your current situation and how you support your family.

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 patient 's family 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: _____

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

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: _____

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: _____