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Hurst, Texas 76054
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Child and Family Application

Application Requirements to be considered for Approval:

- Please print your answers using blue or black ink.
- Application must be completed by the responsible guardian or persons seeking services.
- The child/applicant must be a resident of Texas.
- The child/applicant must have an identified need detailed in the application.
- A separate application must be filled out for each child/applicant in need of services.
- You must provide proof of income from **EACH** adult in the home (*at least ONE of the following*):
 - Two of the most recent paycheck stubs, SSI benefit summary, unemployment benefit check stub, etc.
 - Most recent income tax return
 - Letter from employer (*or most recent employer to verify unemployment*)
- A **Provider Referral Form** or letter of referral must be attached (*if applicable*).
- Do not leave sections blank. Sections that are not applicable please designate as N/A.
- Only completed applications will be reviewed for consideration. Please review **Child and Family Application Checklist** before submitting.

General Information:

- Masonic affiliation is given priority.
- Determination of assistance is not based on gender, religious, racial or ethnic backgrounds.
- The child/applicant and/or legal guardian(s) must actively and positively participate in the treatment and resolution of their case to remain eligible for services.
- The child/applicant and/or legal guardian/s are at liberty to refuse services at anytime.
- The child/applicant and/or legal guardian/s must agree to fill out required surveys/feedback on services received.
- Masonic Home and School of Texas (MHS) considers family expenditures including special circumstance in determining services.
- If other resources are available, they are considered when making a decision regarding application approval.
- Financial support is not guaranteed and is contingent upon eligibility, availability of funds, and a qualified provider.
- MHS may refuse support/services at any time, should staff determine that MHS is no longer able to support/services for the child/applicant.
- The ultimate determination will be by Masonic Home and School of Texas, in its sole discretion.



Child and Family Application Checklist

Before submitting application please ensure that each item in the below checklist is included. Incomplete applications will not be accepted.

- Application for Child and Family Services** (5 pages)
- Consent for Release of Information**
- Authorization to Release Medical Information** (2 pages)
- Provider Referral Form** (If applicable, to be completed by the provider)
 - Treatment Plan** or invoice/bill for services requested
- Dental Provider Referral Form** (If applicable, to be completed by the provider)
 - Treatment Plan** or invoice/bill for services requested
- Proof of income** for each adult in the home
(See *Child and Family Application Requirements* for details)



Application for Child and Family Services

CHILD / APPLICANT'S PERSONAL DATA			
To be completed by applicant's parent or legal guardian. Please print clearly.			
Last Name	First Name	Middle Initial	Suffix (<i>Jr. Sr. Etc.</i>)
Street Address			Apt #
City	State	County	ZIP
Date of Birth (<i>Mo/Day/Yr</i>)	Age	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female
Ethnicity: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific <input type="checkbox"/> Other:			

PARENT / LEGAL GUARDIAN PERSONAL DATA			
If applicant is a minor, please complete the following information:			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			
<i>Mother / Legal Guardian's Information:</i>			
Last Name	First Name	Middle Initial	Suffix (<i>Jr. Sr. Etc.</i>)
Street Address			Apt #
City	State	County	ZIP
Age	Best Phone Number	Alternate Phone Number	
Email			
<i>Father / Legal Guardian's Information:</i>			
Last Name	First Name	Middle Initial	Suffix (<i>Jr. Sr. Etc.</i>)
Street Address			Apt #
City	State	County	ZIP
Age	Best Phone Number	Alternate Phone Number	
Email			



Application for Child and Family Services

OTHER CHILDREN LIVING IN HOUSEHOLD					
Last Name		First Name		Middle Initial	Suffix (<i>Jr. Sr. Etc.</i>)
Date of Birth (<i>Mo/Day/Yr</i>)	Age	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Applicant	
Last Name		First Name		Middle Initial	Suffix (<i>Jr. Sr. Etc.</i>)
Date of Birth (<i>Mo/Day/Yr</i>)	Age	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Applicant	
Last Name		First Name		Middle Initial	Suffix (<i>Jr. Sr. Etc.</i>)
Date of Birth (<i>Mo/Day/Yr</i>)	Age	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Applicant	
Last Name		First Name		Middle Initial	Suffix (<i>Jr. Sr. Etc.</i>)
Date of Birth (<i>Mo/Day/Yr</i>)	Age	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Applicant	

OTHER ADULTS LIVING IN HOUSEHOLD					
Last Name		First Name		Middle Initial	Suffix (<i>Jr. Sr. Etc.</i>)
Place of Employment	Monthly Income	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Applicant	
Last Name		First Name		Middle Initial	Suffix (<i>Jr. Sr. Etc.</i>)
Place of Employment	Monthly Income	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Applicant	



Application for Child and Family Services

MONTHLY EXPENSES	
Rent / Mortgage Payment	\$
Home Insurance	\$
Electric / Gas	\$
Water	\$
Food / Groceries	\$
Home Phone	\$
Mobile Phone	\$
Cable / Satellite / Internet	\$
Car Payment	\$
Gasoline	\$
Car Insurance	\$
Child Care	\$
Health Insurance	\$
Medical Bills	\$
Major Credit Cards (Total Balance: \$ _____)	\$
Loans (Total Balance: \$ _____)	\$
Other (Please Specify): _____	\$
Other (Please Specify): _____	\$
OTHER MONTHLY FINANCIAL SUPPORT	
Child Support	\$
TANF	\$
HOUSING	\$
WIC	\$
CCMS	\$
Food Stamps	\$
Social Security	\$
Other (Please Specify): _____	\$
HOUSEHOLD INCOME	
<i>Mother / Legal Guardian</i>	
Employer name:	Monthly Pay (After Taxes):
* If unemployed, what is the reason and length of time?:	
<i>Father / Legal Guardian</i>	
Employer name:	Monthly Pay (After Taxes):
*If unemployed, what is the reason and length of time?:	

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
(HIPAA AUTHORIZATION UNDER 45 §164.508)
CHILD

STATEMENT OF INTENT

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), that there are federal regulations that interpret and implement that law, and that HIPAA limits disclosure of my child's Individually Identifiable Health Information to certain of my family and friends, regardless of my child's state of health. I am signing this authorization so my child's Health Care Providers can disclose my child's health care information to the persons listed below, and openly discuss that information with them.

AUTHORIZATION

I, _____, am the parent, guardian or managing conservator of _____ ("my child"). I hereby authorize my child's physicians, nurses, hospitals and other Health Care Providers to fully disclose my child's Individually Identifiable Health Information to the Masonic Home and School of Texas, 338 Grapevine Hwy., Hurst, TX 76054, 817-503-1500 (my child's "Personal Representatives").

AUTHORITY TO DISCUSS AND ANSWER QUESTIONS

My child's Health Care Providers are expressly authorized to answer questions posed by the Personal Representatives listed above and openly discuss with them my child's condition, treatment, test results, prognosis, and everything pertinent to my child's health care, even if I am fully competent to ask questions and discuss this matter at the time. This document constitutes a full authorization to disclose ANY of my child's Individually Identifiable Health Information to the Personal Representatives named in this Authorization.

WAIVER AND RELEASE

I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Information and for any actions taken by my child's Personal Representatives.

TERMINATION

This Authorization is effective as of the date shown as the date of its signing, and shall not be affected by my subsequent disability or incapacity. This authorization shall terminate on this first to occur of: (1) two years following my child's death or (2) upon my written revocation actually received by the Health Care Provider, proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the Health Care Provider.

RE-DISCLOSURE

By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Personal Representatives named in this Authorization and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me or my child embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I fully indemnify my child's Health Care Providers for all consequences which may occur as a result of their good faith reliance and compliance with this Authorization. No Health Care Provider shall require my child's Personal Representatives to indemnify the Health Care Provider or agree to perform any act in order for the Health Care Provider to comply with this Authorization.

ENFORCEMENT

My child’s Personal Representatives shall have the right to bring a legal action in any applicable forms against any Health Care Provider that refuses to recognize and accept this Authorization. Additionally, my child’s Personal Representatives are authorized to sign any documents that my child’s Personal Representatives deem necessary or appropriate to obtain my child’s Individually Identifiable Health Information.

CONFLICTS WITH OTHER AUTHORIZATIONS

This Authorization is in addition to other medical release authorizations I may have granted in the past or future. It does not replace them. This Authorization may be relied upon by my child’s Health Care Providers regardless of any real or perceived conflict with any Medical Power of Attorney signed by me, whether prior to or subsequent to the date of this Authorization. I recognize and intend that this will result in multiple persons having the authority to obtain my child’s protected Individually Identifiable Health Information. This Authorization is not intended to replace a Medical Power of Attorney, nor to grant any person the authority to make health care decisions, but merely to obtain information and explanations.

COPIES

A copy or facsimile of this original Authorization may be accepted and relied upon as though it was an original document.

DEFINITIONS

The term "*Individually Identifiable Health Information*" includes (but is not limited to) the following:

All health care information, reports and/or records concerning my child’s medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identify of health care providers and insurers, whether past, present or future and any other medical information which is in any way related to my child’s health care. In this Authorization, the term also includes the term "Protected Medical Information," as sometimes used in HIPAA.

The term "*Health Care Providers*" includes (but is not limited to) the following:

Doctors (including but not limited to physicians, podiatrists, chiropractors, and osteopaths), psychiatrists, psychologists, dentists, therapists, nurses, hospitals, clinics, pharmacies, laboratories, ambulance services, assisted living facilities, residential care facilities, bed and board facilities, nursing homes, medical insurance companies or any other medical providers, or affiliates. In this Authorization, the term also includes the term "Covered Entity," as sometimes used in HIPAA.

Signature of Parent, Guardian or Managing Conservator

Parent, Guardian or Managing Conservator Name *(Please Print)*

Date