MASONIC CHILDREN & FAMILY SERVICES —OF TEXAS—

1240 Keller Parkway, Suite #200
Keller, TX 76248
phone: 817.503.1500
toll-free: 877.203.9111
fax: 817.503.1551
www.mcfstx.org
donya@mcfstx.org

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 but be a resident of Texas, age 21 or younger.
- 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.
- Be thorough. Masonic Children & Family Services of Texas (MCFS) considers family expenditures, including special circumstances, 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.
- MCFS may refuse support/services at any time, should staff determine that MCFS is no longer able to support/services for the child/applicant.
- The ultimate determination will be by Masonic Children & Family Services of Texas, in its sole discretion.

MASONIC CHILDREN & FAMILY SERVICES — OF TEXAS —

Child and Family Application CHECKLIST

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

- ☐ **Application for Child and Family Services** *(5 pages)*
- ☐ **Consent for Release of Information** *(1 pages)*
- ☐ **Authorization to Release Medical Information** *(2 pages)*
- ☐ **Proof of Income** for each adult in the home *(Including SSI, food stamps, disability)*

Submit Provider Referral Form and related documents if requesting funding on behalf of a child for anything EXCEPT dental services.

- ☐ **Provider Referral Form** To be completed by the provider
  - ☐ **Treatment Plan** — Detailing services requested and cost
  - ☐ **Insurance Coverage Details** — Denial letter from insurance company or deductible met so far
  - ☐ **Diagnosis from pediatrician or specialist** — Required for ABA, speech, or occupational therapy, and cranial helmets

MASONIC CHILDREN & FAMILY SERVICES OF TEXAS

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 *(Jr. Sr. Etc.)*

Street Address	Apt #

City	State	County	ZIP

Date of Birth *(Mo/Day/Yr)*	Age	Grade	☐ Male ☐ Female

Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian/Pacific ☐ Other:

PARENT / LEGAL GUARDIAN PERSONAL DATA

If applicant is a minor, please complete the following information:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Mother / Legal Guardian's Information:

Last Name	First Name	Middle Initial	Suffix *(Jr. Sr. Etc.)*

Street Address	Apt #

City	State	County	ZIP

Age	Best Phone Number	Alternate Phone Number

Email

Father / Legal Guardian's Information:

Last Name	First Name	Middle Initial	Suffix *(Jr. Sr. Etc.)*

Street Address	Apt #

City	State	County	ZIP

Age	Best Phone Number	Alternate Phone Number

Email

MASONIC CHILDREN & FAMILY SERVICES OF TEXAS

Application for Child and Family Services

What services are you requesting for the Child/Applicant? *List in order of importance:*		
1.	2.	3.

Explain why the child needs the services you are requesting.

Have you asked for OR received assistance from other resources? Please explain.

How have you been taking care of your child / family's needs until now?

How did you hear about Masonic Child & Family Services of Texas? ***(Specific agency name/ friend/ relative)***

Application for Child and Family Services

MASONIC CHILDREN & FAMILY SERVICES OF TEXAS

OTHER CHILDREN LIVING IN HOUSEHOLD

Last Name	First Name	Middle Initial	Suffix *(Jr. Sr. Etc.)*

Date of Birth *(Mo/Day/Yr)*	Age	Grade	☐ Male ☐ Female	Relationship to Applicant

Last Name	First Name	Middle Initial	Suffix *(Jr. Sr. Etc.)*

Date of Birth *(Mo/Day/Yr)*	Age	Grade	☐ Male ☐ Female	Relationship to Applicant

Last Name	First Name	Middle Initial	Suffix *(Jr. Sr. Etc.)*

Date of Birth *(Mo/Day/Yr)*	Age	Grade	☐ Male ☐ Female	Relationship to Applicant

Last Name	First Name	Middle Initial	Suffix *(Jr. Sr. Etc.)*

Date of Birth *(Mo/Day/Yr)*	Age	Grade	☐ Male ☐ Female	Relationship to Applicant

Last Name	First Name	Middle Initial	Suffix *(Jr. Sr. Etc.)*

Date of Birth *(Mo/Day/Yr)*	Age	Grade	☐ Male ☐ Female	Relationship to Applicant

OTHER ADULTS LIVING IN HOUSEHOLD

Last Name	First Name	Middle Initial	Suffix *(Jr. Sr. Etc.)*

Place of Employment	Monthly Income	Age	☐ Male ☐ Female	Relationship to Applicant

Last Name	First Name	Middle Initial	Suffix *(Jr. Sr. Etc.)*

Place of Employment	Monthly Income	Age	☐ Male ☐ 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	
Mother / Legal Guardian	
Employer name:	Monthly Pay *(After Taxes)*:
* If unemployed, what is the reason and length of time?	
Father / Legal Guardian	
Employer name:	Monthly Pay *(After Taxes)*:
*If unemployed, what is the reason and length of time?	

MASONIC CHILDREN & FAMILY SERVICES —OF TEXAS—

Application for Child and Family Services

ADDITIONAL INFORMATION

Please check the type of health coverage that applies to the child / applicant:

☐ No Coverage ☐ Medicaid ☐ CHIP ☐ CSHCN

☐ Other Health Coverage: _____ ☐ Other Dental Coverage: _____

MASONIC AFFILIATION

Note: Application may be submitted without this portion being completed if no Mason was involved in the referral

☐ Yes ☐ No	If yes, Mason's name:
Lodge Name/Number:	
Relation: ☐ Father ☐ Grandfather ☐ Great-Grandfather ☐ Uncle ☐ Other:	

Personal Recommendation by a Texas Master Mason *Complete only if applicable*

_____

Print Name Signature Date

_____

Lodge Name Lodge Number

AUTHORIZATION

I acknowledge that Masonic Children & Family Services of Texas (MCFS) will rely on the information in this application while making its decisions about this request. I authorize MCFS to consult with, or release information to any person whom they deem necessary to verify this information and the request. I understand it is sometimes necessary for MCFS to do this in order to make its decision about my request. I also understand that MCFS may use Presbyterian Children's Homes and Services (PCHAS) to assist with assessing my request. MCFS may disclose my information to PCHAS. PCHAS staff may contact me as part of the assessment. This authorization expires one year from the date below.

Signature: _____ Date: _____

Parent/Legal Guardian of Applicant

If someone other than the person signing above filled out this application, please complete the following:

_____ _____

Name Relationship to Applicant

_____ _____

Agency and/or Title Phone

_____ _____

Address City, State, Zip

MASONIC CHILDREN & FAMILY SERVICES OF TEXAS
CONSENT FOR RELEASE OF INFORMATION
CHILD

Declaring myself to be legally responsible for: _____
(please print name of child)

I, _____, on behalf of my child and myself voluntarily and hereby give permission to The Grand Lodge of Texas and Masonic Children & Family Services of Texas to release (1) my application; (2) information from my application; and (3) any records, including documents, information, photographs or film which I have provided to, or allowed to be taken by, Masonic Children & Family Services of Texas at this time or may provide, or allow to be taken, at any time in the future (including Individually Identifiable Health Information) and for any information which Masonic Children & Family Services of Texas may receive from third parties to any third party provider services which I am seeking through any Masonic Children & Family Services of Texas program and to any social worker conducting a needs assessment or creating or revising a plan of treatment. I further give my permission to release (1) my application; (2) information from my application; and (3) any records, including documents, plan of treatment information, length of treatment information, photographs or film which I have provided to, or allowed to be taken by, any third party provider or social worker to Masonic Children & Family Services of Texas. I further understand and agree that all such information may be used for budget balancing, and service development.

I further understand and agree that all such information shall be the property of Masonic Children & Family Services of Texas and may be used by Masonic Children & Family Services of Texas for public development and awareness, publicity items, brochures, promotional materials and media releases.

I further understand and agree that in order to receive services under the Masonic Children & Family Services of Texas program, my application may have to be reviewed and approved by one or more members of the Masonic Fraternity and/or Masonic Lodge. I hereby consent to the release of my application for those purposes.

I agree to save and hold harmless, The Grand Lodge of Texas, Masonic Children & Family Services of Texas, their officers, directors, staff and other personnel and agents from any and all action results from this consent.

_____		_____	
Parent/Managing Conservator Signature	**Date**	**Staff Signature**	**Date**
_____		_____	
Parent/Managing Conservator Signature	**Date**	**Staff Signature**	**Date**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
(HIPPA 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 Children & Family Services of Texas, 1240 Keller Parkway, Suite #200, Keller, TX 76248, 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

MASONIC CHILDREN & FAMILY SERVICES OF TEXAS

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Provider Referral Form

ABOUT US: Masonic Children & Family Services is a non-profit children's charity that has been helping to meet the needs of underserved children in the state of Texas for more than a century. **With that in mind**, we appreciate your consideration in providing discounted pricing for services. MCFS pays providers directly upon invoicing for services rendered. Should you have additional questions, please contact our office at 817.503.1500.

Date: _____

To be completed by provider (please print)			
Child's Last Name	First Name	Middle	Suffix *(Jr. Sr. Etc.)*
Date of Birth *(Mo/Day/Yr)*	Age	☐ Male ☐ Female	

PROVIDER'S REFERRAL FOR SERVICES *Treatment plan REQUIRED with each referral* ***** *If medically-related, attach official diagnosis letter from physician*		
Purpose of Referral:		
Describe Problem or need:		
ESTIMATED COST OF SERVICES	**Regular Rate:**	**Discounted Rate:**
How much of the above cost are you requesting from MCFS:		
Pertinent exam findings and history, if applicable. **ATTACH TREATMENT PLAN**.		

PROVIDER'S INFORMATION		
Provider's Company Name: _____		
Signature of Provider's Representative: _____		
Provider's Address: _____ *Suite #*		
_____ *City* *State* *County* *ZIP*		
Phone	Fax	Email

THIRD PARTY INFORMATION *Please attach contact information if a third party will be supplying/performing the need/service.*	
☐ Not Applicable	☐ Contact Information Follows