



Dear Patient Family,

Thank you for choosing Scottish Rite for Children as your care provider. Our mission is to provide premiere health care services to our patients regardless of the family's ability to pay. To support our mission, we have a Financial Assistance/Charity Care Program designed to help families ease the burden of medical expenses according to their financial needs.

The enclosed form applies to all families regardless of income levels and insurance types. You may qualify for care at no charge or at a significantly discounted rate.

Regardless of your current insurance (Medicaid, Blue Cross Blue Shield, Aetna, etc.) please take the time to fill out this application so that we may better serve you. If you have any questions regarding this form please feel free to call 214-559-8630 and a Family Services Counselor will be happy to provide more details about our Family Assistance/Charity Care Program, answer any questions you may have, or assist you in any of your needs.

Thank you again for choosing Scottish Rite for Children and please take a few minutes now to fill out the attached form.





Patient ID Number: _____

Financial Assistance/Charity Care Application

Patient Name: _____ DOB: _____ Sex: Male / Female

Telephone Number: _____ SSN: _____

Address: _____ County: _____
Street / City / State / Zip Code

Caregiver/ Guardian Information	Caregiver / Guardian Information
Name: _____ DOB: _____	Name: _____ DOB: _____
Relationship to Patient: _____	Relationship to Patient: _____
Address: _____ <small>Street / City / State / Zip Code</small>	Address: _____ <small>Street / City / State / Zip Code</small>
SSN: _____	SSN: _____
Phone: _____	Phone: _____
Employer: _____ <small>Name / Street / City / State / Zip Code</small>	Employer: _____ <small>Name / Street / City / State / Zip Code</small>

Patient's Siblings in the Same Household				
Name	DOB	Age	Sex	Also Scottish Rite for Children Patient (seen in last 12 Months)
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Marital Status of Caregivers: Married Divorced Separated Single Widowed

What insurance(s) (if any) does the patient currently have?

None Medicaid CHIP Commercial Insurance: _____ Other : _____

Policy Number: _____ Group Number: _____

Who is listed as the subscriber on the patient's insurance? _____

Eligibility Information
<p>Please provide the income for each of the following persons in your household (if applicable).</p> <p style="text-align: center;">Circle one</p> <p>Patient \$ _____ Hr/ Wk /2xMonth /Bi-weekly /Year Patient's Caregiver/Guarantor \$ _____ Hr /Wk/2xMonth /Bi-weekly /Year</p> <p>Patient's Caregiver / Guarantor \$ _____ Hr /Wk /2xMonth /Bi-weekly /Year Other \$ _____ Hr /Wk /2xMonth /Bi-weekly /Year</p> <p>Family Gross Income*: \$ _____</p> <p><small>* Gross Income is the sum of the gross income of the patient, patient's mother, patient's father and/or other responsible party.</small></p> <p>Unreimbursed Medical Expenses*: \$ _____</p> <p><small>*These are the annualized and unreimbursed costs incurred by the family and include bills for services provided by the Scottish Rite for Children and other unreimbursed medical expenses.</small></p> <p>Number of Family Members living in household*: _____</p> <p><small>*This number is to include the patient, patient's mother, patient's father, dependents of the patient's mother and dependents of the patient's father.</small></p> <p>Income Verification: Provide documentation that reflects total household wages or proof of participation in a government assistance program.</p>

Financial Assistance/Charity Care Application

Please **initial** below:

- _____ I/we declare that the answers I/we have given on this application are true and correct to the best of my/our knowledge.
- _____ I/we agree to tell Scottish Rite for Children as soon as possible, if there are any changes in the information provided in this application.
- _____ I/we understand that Scottish Rite for Children is required by law to keep any information I/we provide confidential.
- _____ I/we further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse Scottish Rite for Children from proceeds of any litigation or settlement resulting from such act.
- _____ I/we understand that if I/we do not qualify for uncompensated services, I/we will be personally liable for the charges of the services rendered by Scottish Rite for Children and that I/we may appeal decision in writing with additional documentation.

If unable to provide proof of income, please explain why:

I/we ask Scottish Rite for Children to determine if I/we are eligible for help in paying for my/our child's bill. I/we understand that I/we need to give certain information for this to be done. I/we also understand that Scottish Rite for Children or its agents may check these facts for accuracy and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I am (we are) aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance. I /we understand that filling out this form does not guarantee that I/we will receive this help. If I am (we are) not eligible for uncompensated services, I am (we are) responsible for my/our child's Scottish Rite for Children bill.

Signature of Caregiver/Guardian: _____ Date: _____

Signature of Caregiver/Guardian: _____ Date: _____

Remember to submit: Income verification & if applicable, proof of 1% of your annual gross income in medical expenses for the family from the past 12 months.

FOR OFFICE USE ONLY

Family qualifies for a discount of _____% on all Scottish Rite for Children Charges; provided, however, that the amount due after such discount will in all cases be limited to 1% of the family's gross income. The amount due, after application of the discount, is: \$_____).

Some portions of this application were completed by a Scottish Rite for Children staff member. Those areas have been identified by the staff member's initials.

Printed Name: _____

Signature: _____ **Date:** _____



Financial Assistance Check List

- Complete financial assistance application _____
- Provide household income documentation for each income source (if applicable) _____
- Household is defined in this table based on the child’s insurance

CHILD’S INSURANCE	DEFINITION OF “HOUSEHOLD”
Commercial Insurance (Blue Cross / Blue Shield, Aetna, United, Cigna, etc...)	Guarantor’s Household
Medicaid or other state funding	Household where the child lives
Uninsured	Household of the person who claims the child on annual tax return

- o Most current tax statement or pay check stub
- o Proof of Social Security payment or workers’ compensation
- o Unemployment insurance payment notice; unemployment compensation determination letter; or other appropriate indicators of the family’s reported income
- o Documentation showing current participation in a public benefit program such as Medicaid; County Indigent Health Care Program; TANF; Food Stamps; WIC; TexCare Partnership; or other similar indigency-related programs
- Provide proof of 1% of your annual gross income in medical expenses for the family from the past 12 months _____
- Include a copy of your current health insurance card(s) _____
- Stamp and mail financial assistance application to the following address: _____
OR fax it to the fax number below:
- o Scottish Rite for Children
Attn: Family Service Counselors
2222 Welborn Street; Dallas, TX 75219-3993
FAX:214-443-7331
EMAIL: FamilyServicesCounselors@tsrh.org

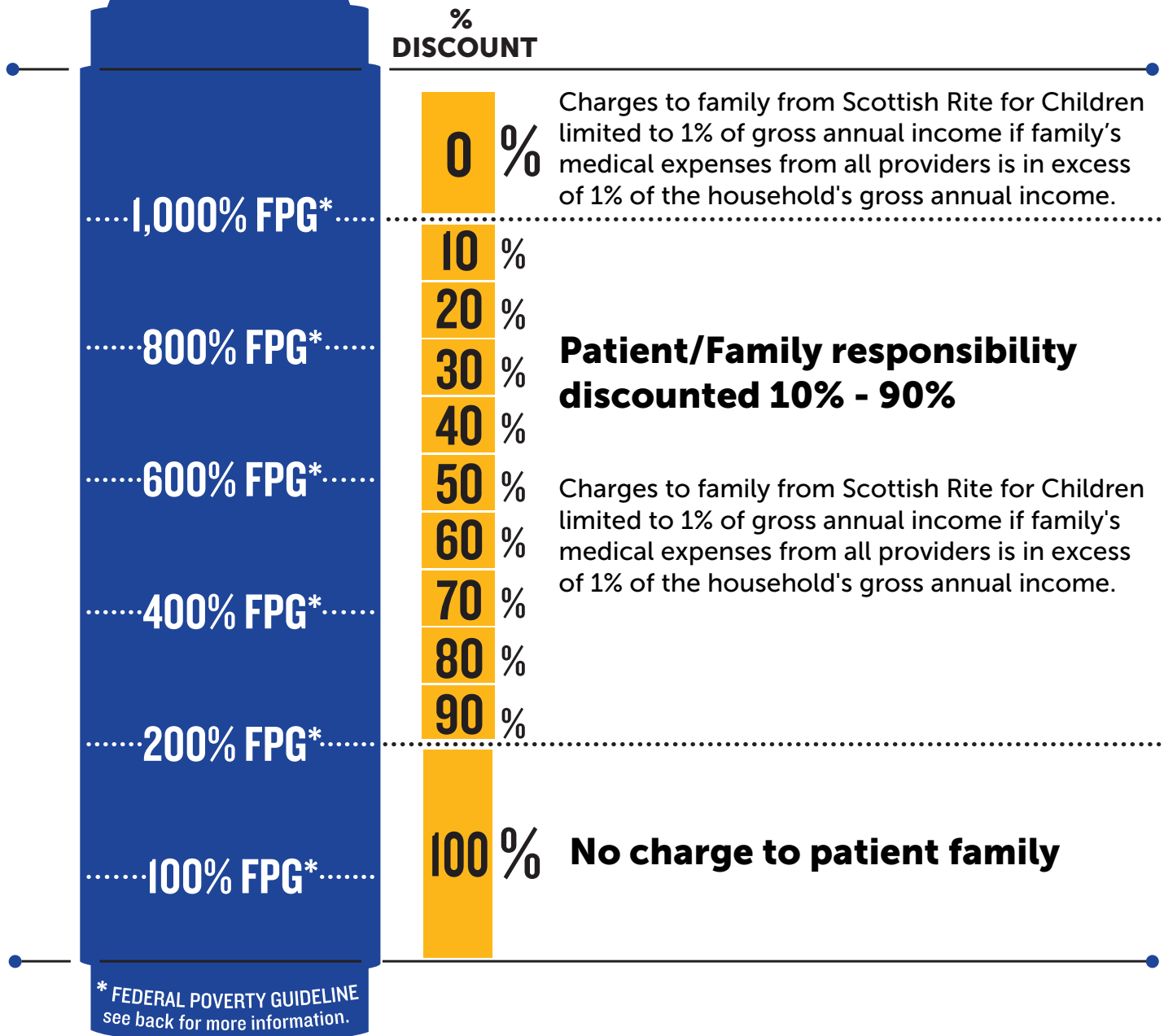
If you have any questions about your account, please call our Family Service Counselors at
214-559-8630





CRAYON CARE

SCOTTISH RITE FOR CHILDREN



APPLICATION PROCESS

- Complete application
- Provide proof of household income and proof of medical expenses for the family from the past 12 months
- Proof of enrollment in Government Assistance Program (Medicaid, CHIP, Food Stamps, WIC, etc.) if applicable

CONTACT INFO FOR FAMILY SERVICES COUNSELORS

DALLAS CAMPUS
214-559-8630

FRISCO CAMPUS
469-515-7191



QUALIFICATION AND DISCOUNT SCALES

2022 Federal Poverty Guidelines as established by the Department of Health & Human Services
\$23,030 Federal Poverty Limit for a household of three dependents

Household Size		3 or less
Income Range		Discount
\$0	\$46,060	100%
\$46,061	\$69,090	90%
\$69,091	\$92,120	80%
\$92,121	\$115,150	70%
\$115,151	\$138,180	60%
\$138,181	\$161,210	50%
\$161,211	\$184,240	40%
\$184,241	\$207,270	30%
\$207,271	\$218,785	20%
\$218,786	\$230,300	10%
\$230,301	and up	0%

Household Size		4
Income Range		Discount
\$0	\$55,500	100%
\$55,501	\$83,250	90%
\$83,251	\$111,000	80%
\$111,001	\$138,750	70%
\$138,751	\$166,500	60%
\$166,501	\$194,250	50%
\$194,251	\$222,000	40%
\$222,001	\$249,750	30%
\$249,751	\$263,625	20%
\$263,626	\$277,500	10%
\$277,501	and up	0%

Household Size		5
Income Range		Discount
\$0	\$64,940	100%
\$64,941	\$97,410	90%
\$97,411	\$129,880	80%
\$129,881	\$162,350	70%
\$162,351	\$194,820	60%
\$194,821	\$227,290	50%
\$227,291	\$259,760	40%
\$259,761	\$292,230	30%
\$292,231	\$308,465	20%
\$308,466	\$324,700	10%
\$324,701	and up	0%

Household Size		6
Income Range		Discount
\$0	\$74,380	100%
\$74,381	\$111,570	90%
\$111,571	\$148,760	80%
\$148,761	\$185,950	70%
\$185,951	\$223,140	60%
\$223,141	\$260,330	50%
\$260,331	\$297,520	40%
\$297,521	\$334,710	30%
\$334,711	\$353,305	20%
\$353,306	\$371,900	10%
\$371,901	and up	0%

Household Size		7
Income Range		Discount
\$0	\$83,820	100%
\$83,821	\$125,730	90%
\$125,731	\$167,640	80%
\$167,641	\$209,550	70%
\$209,551	\$251,460	60%
\$251,461	\$293,370	50%
\$293,371	\$335,280	40%
\$335,281	\$377,190	30%
\$377,191	\$398,145	20%
\$398,146	\$419,100	10%
\$419,101	and up	0%

Household Size		8
Income Range		Discount
\$0	\$93,260	100%
\$93,261	\$139,890	90%
\$139,891	\$186,520	80%
\$186,521	\$233,150	70%
\$233,151	\$279,780	60%
\$279,781	\$326,410	50%
\$326,411	\$373,040	40%
\$373,041	\$419,670	30%
\$419,671	\$442,985	20%
\$442,986	\$466,300	10%
\$466,301	and up	0%

Household Size		9
Income Range		Discount
\$0	\$102,700	100%
\$102,701	\$154,050	90%
\$154,051	\$205,400	80%
\$205,401	\$256,750	70%
\$256,751	\$308,100	60%
\$308,101	\$359,450	50%
\$359,451	\$410,800	40%
\$410,801	\$462,150	30%
\$462,151	\$487,825	20%
\$487,826	\$513,500	10%
\$513,501	and up	0%

Household Size		10
Income Range		Discount
\$0	\$112,140	100%
\$112,141	\$168,210	90%
\$168,211	\$224,280	80%
\$224,281	\$280,350	70%
\$280,351	\$336,420	60%
\$336,421	\$392,490	50%
\$392,491	\$448,560	40%
\$448,561	\$504,630	30%
\$504,631	\$532,665	20%
\$532,666	\$560,700	10%
\$560,701	and up	0%

