
SHRINERS HOSPITALS FOR CHILDREN APPLICATION INSTRUCTIONS

1. Complete pages 1 and 2 of the application. Do not complete the "Sponsoring Shriner" section, the sections marked "For Hospital Use Only," or the "Chief of Staff" or "Board of Governors" sections.
2. Send the completed application to the nearest Shriners Hospital (listed below).
3. The parents or guardian will be notified if the child is accepted for treatment at Shriners Hospitals.
3. If you have any questions, call toll-free 1-800-237-5055 (in the United States) or 1-800-361-7256 (in Canada).

ORTHOPAEDIC CARE

* Chicago	2211 N. Oak Park Ave. Chicago, IL 60707 773-622-5400
Erie	1645 W. 8th St. Erie, PA 16505 814-875-8700
Greenville	950 West Faris Road Greenville, SC 29605-4277 864-271-3444
Honolulu	1310 Punahou St. Honolulu, HI 96826-1099 808-941-4466
Houston	6977 Main Houston, TX 77030-3701 713-797-1616
Lexington	1900 Richmond Rd. Lexington, KY 40502 606-266-2101
Los Angeles	3160 Geneva St. Los Angeles, CA 90020 213-388-3151
Mexico City	Suchil No. 152, Col. El Rosario Delg. Coyoacan, 04380 Mexico, D.F., Mexico 011-525-618-1120
Minneapolis	2025 E. River Parkway Minneapolis, MN 55414 612-596-6100
Montreal	1529 Cedar Ave. Montreal, Quebec, Canada H3G 1A6 514-842-4464
*Philadelphia	3551 North Broad Street Philadelphia, PA 19140 215-430-4000

Portland	3101 S.W. Sam Jackson Park Road Portland, OR 97201-5090 503-241-5090
Salt Lake City	Fairfax Road at Virginia Street Salt Lake City, UT 84103 801-536-3500
Shreveport	3100 Samford Ave. Shreveport, LA 71103 318-222-5704
Spokane	911 W. Fifth Ave. Spokane, WA 99204-2901 509-455-7844
Springfield	516 Carew St. Springfield, MA 01104 413-787-2000
St. Louis	2001 S. Lindbergh Blvd. St. Louis, MO 63131-3597 314-432-3600
Tampa	12502 North Pine Dr. Tampa, FL 33612-9499 813-972-2250

BURN CARE

Boston	51 Blossom St. Boston, MA 02114 617-722-3000
Cincinnati	3229 Burnet Ave. Cincinnati, OH 45229-3095 513-872-6000
Galveston	815 Market St. Galveston, TX 77550-2725 409-770-6600

ORTHOPAEDIC AND BURN CARE

*Sacramento	2425 Stockton Blvd. Sacramento, CA 95817 916-453-2000
--------------------	---

** Includes Spinal Cord Injury Rehabilitation Center*

**APPLICATION FORM
SHRINERS HOSPITALS FOR CHILDREN**

To be completed by parent or guardian

Name of Child: _____
(Last) (First) (Middle)

Permanent Home Address: _____
(Street) (City/Town) (County)

(State/Province) (Zip Code) (Country)

Mailing Address: _____
(if different) (Street) (City/Town) (County)

Home #: _____ Alternate # _____
(Area Code) (Phone Number) (Area Code) (Phone Number)

Date of Birth: ____/____/____ Sex: M F Child's Social Security No.: _____ - _____ - _____

Who does child live with primarily? (Circle One) 1. Both Parents 2. Mother 3. Father 4. Other (Name) _____

Name of Mother: _____
(Last) (First) (Middle) (Maiden)

Address: _____
(Street) (City/Town) (County) (State/Province) (Zip)

Home #: _____ Work # _____
(Area Code) (Phone Number) (Area Code) (Phone Number)

Marital Status: (Circle One) Single Married Separated Divorced Widowed

Name of Father: _____
(Last) (First) (Middle)

Address: _____
(If Different From Mother) (Street) (City/Town) (County) (State/Province) (Zip)

Home #: _____ Work # _____
(Area Code) (Phone Number) (Area Code) (Phone Number)

Marital Status: (Circle One) Single Married Separated Divorced Widowed

Name of Legal Guardian: _____
(If Different From Above) (Last) (First) (Middle)

Relationship to child: _____

Address: _____
(Street) (City/Town) (County) (State/Province) (Zip)

Home #: _____ Work # _____
(Area Code) (Phone Number) (Area Code) (Phone Number)

(continued on reverse)

To be completed by Sponsoring Shriner

SPONSORING SHRINER INFORMATION

Sponsoring Shriner's Temple: _____ MOOLAH _____

Shriner's Name: _____ James Tracy _____

Shriner's Address: _____ 4678 Britcastle Drive St. Louis Missouri 63128 Daytime Phone: _____ 314 487-6008 _____
(Street) (City/Town) (State/Province) (Zip) (Area Code) (Number)

_____ James Tracy _____ 12/02/02 _____
Sponsoring Shriner's Signature Date

FOR HOSPITAL USE ONLY:

Return To: _____ Hospital
Address: _____

Date Received: _____
Application Number: _____
Date of Screening Visit: _____
Medical Record Number: _____
Name of Person Initiating Form: _____

Name of Child: _____

MEDICAL INFORMATION

Problem or Diagnosis (if known): _____

_____ Date First Noticed: _____

Chief complaint (symptom) describe: _____

How long has the child had the problem: From birth Developed recently Injury Date: _____

What other symptoms does your child have (describe) _____

Currently Under Care of:	Physician	Hospital
Name:	_____	_____
Address:	_____	_____
Phone #:	_____	_____

Treatment Provided: _____

Surgery/Dates: _____

Other treatment/Dates: _____

X-rays: Yes No Date of most recent X-ray _____ (should bring to first visit)

When was child last seen by doctor: _____

Has child been treated at another Shriners Hospital Yes No Date of treatment _____

Location/City: _____

FINANCIAL INFORMATION

Total combined family	<input type="checkbox"/> \$1-\$10,000	<input type="checkbox"/> \$10,000-\$20,000	<input type="checkbox"/> \$20,000-\$30,000
income for last 12 months	<input type="checkbox"/> \$30,000-40,000	<input type="checkbox"/> \$40,000-\$50,000	<input type="checkbox"/> over \$50,000

INSURANCE INFORMATION

Type Private HMO Medicaid Medicare State Agency Other None

Name of Company or Health Plan: _____

ID Number: _____

Name of HMO Physician: _____

(If this application is approved, further insurance information may be requested by the Hospital in order to assist with services not performed at Shriners Hospitals.)

Name of Person Completing Form: _____ Relationship _____ Date _____

FOR HOSPITAL USE ONLY: CHIEF OF STAFF RECOMMENDATIONS

Accept Reject Screen

Reason for Rejection: _____

Signature — Chief of Staff _____ Date _____

ACTION BOARD OF GOVERNORS

Approved Denied

Reason for Denial: Medical Financial Non-Compliance Foreign Patient Policy
Overage Other _____

Signature _____ Date _____
