CRAYON CARE
SCOTTISH RITE FOR CHILDREN

Dear Patient Family,

Thank you for choosing Scottish Rite for Children as your care provider. Our mission is to provide premier 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.

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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: _____ Street / City / State / Zip Code	Address: _____ Street / City / State / Zip Code
SSN: _____	SSN: _____
Phone: _____	Phone: _____
Employer: _____ Name / Street / City / State / Zip Code	Employer: _____ Name / Street / City / State / Zip Code

Patient's Siblings in the Same Household

Name	DOB	Age	Sex	Also Scottish Rite for Children Patient (seen in last 12 Months)
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ 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

Please provide the income for each of the following persons in your household (if applicable).

Circle one

Patient $ _____Hr/ Wk /2xMonth /Bi-weekly /Year Patient's Caregiver/Guarantor $ _____Hr /Wk/2xMonth /Bi-weekly /Year

Patient's Caregiver / Guarantor $_____ Hr /Wk /2xMonth /Bi-weekly /Year Other $ _____Hr /Wk /2xMonth /Bi-weekly /Year

Family Gross Income*: $_____

* Gross Income is the sum of the gross income of the patient, patient's mother, patient's father and/or other responsible party.

Unreimbursed Medical Expenses*: $_____

*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.

Number of Family Members living in household*: _____

*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.

Income Verification: **Provide documentation that reflects total household wages or proof of participation in a government assistance program.**

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:** _____

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Financial Assistance Checklist

☐ ***Complete financial assistance application (2 pages)***

☐ ***Provide household income documentation for each income source (if applicable)***

- Household is defined in this table based on the child's insurance:

Commercial Insurance	Insurance Subscriber'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

- Examples of household income documentation include:
  - Most current tax return
  - Pay-check stub (each income earner)

- Other examples of documentation, if applicable:
  - Proof of Social Security payment or workers' compensation
  - Unemployment insurance payment notice, compensation determination letter
  - Current participation in a public benefit program such as Medicaid; County Indigent Health Care Program; TANF; Food Stamps: WIC, etc.

☐ ****Provide proof of non-Scottish Rite medical expenses for anyone in the household for the last 12 months.***

- Eligible expenses include medical, dental, vision, prescription and medical equipment.

- Examples include:
  - Explanation of benefits (EOB) from your insurance company
  - Receipts and/or statements showing patient portion
  - Itemized bills; HSA or FSA card statements

- * If your income is <u>less than</u> the amount listed below for your household size, you <u>DO NOT</u> need to submit medical expenses and can skip to the next step.

Household Size	Income		Household Size	Income
3 or less	$53,300		7	$97,300
4	$64,300		8	$108,300
5	$75,300		9	$119,300
6	$86,300		10	$130,300

☐ ***Include a copy of your current health insurance card(s)***

☐ ***Mail, fax or scan and email the application and all supporting documentation to:***

Scottish Rite for Children
Attn: Family Service Counselors
2222 Welborn Street; Dallas, TX 75219-3993
FAX:214-443-7331
EMAIL: FamilyServicesCounselors@tsrh.org
PHONE: 214-559-8630

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0 % Charges to family from Scottish Rite for Children limited to 1% of gross annual income if family's medical expenses from all providers is in excess of 1% of the household's gross annual income.

10 %
20 %
30 %
40 %

Patient/Family responsibility discounted 10% - 90%

50 %
60 %
70 %
80 %
90 %

Charges to family from Scottish Rite for Children limited to 1% of gross annual income if family's medical expenses from all providers is in excess of 1% of the household's gross annual income.

100 % **No charge to patient family**

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

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QUALIFICATION AND DISCOUNT SCALES

2025 Federal Poverty Guidelines as established by the Department of Health & Human Services
$26,650 Federal Poverty Limit for a household of three dependents

Household Size		3 or less
Income Range		Discount
$0	$53,300	100%
$53,301	$79,950	90%
$79,951	$106,600	80%
$106,601	$133,250	70%
$133,251	$159,900	60%
$159,901	$186,550	50%
$186,551	$213,200	40%
$213,201	$239,850	30%
$239,851	$253,175	20%
$253,176	$266,500	10%
$266,501	and up	0%

Household Size		4
Income Range		Discount
$0	$64,300	100%
$64,301	$96,450	90%
$96,451	$128,600	80%
$128,601	$160,750	70%
$160,751	$192,900	60%
$192,901	$225,050	50%
$225,051	$257,200	40%
$257,201	$289,350	30%
$289,351	$305,425	20%
$305,426	$321,500	10%
$321,501	and up	0%

Household Size		5
Income Range		Discount
$0	$75,300	100%
$75,301	$112,950	90%
$112,951	$150,600	80%
$150,601	$188,250	70%
$188,251	$225,900	60%
$225,901	$263,550	50%
$263,551	$301,200	40%
$301,201	$338,850	30%
$338,851	$357,675	20%
$357,676	$376,500	10%
$376,501	and up	0%

Household Size		6
Income Range		Discount
$0	$86,300	100%
$86,301	$129,450	90%
$129,451	$172,600	80%
$172,601	$215,750	70%
$215,751	$258,900	60%
$258,901	$302,050	50%
$302,051	$345,200	40%
$345,201	$388,350	30%
$388,351	$409,925	20%
$409,926	$431,500	10%
$431,501	and up	0%

Household Size		7
Income Range		Discount
$0	$97,300	100%
$97,301	$145,950	90%
$145,951	$194,600	80%
$194,601	$243,250	70%
$243,251	$291,900	60%
$291,901	$340,550	50%
$340,551	$389,200	40%
$389,201	$437,850	30%
$437,851	$462,175	20%
$462,176	$486,500	10%
$486,501	and up	0%

Household Size		8
Income Range		Discount
$0	$108,300	100%
$108,301	$162,450	90%
$162,451	$216,600	80%
$216,601	$270,750	70%
$270,751	$324,900	60%
$324,901	$379,050	50%
$379,051	$433,200	40%
$433,201	$487,350	30%
$487,351	$514,425	20%
$514,426	$541,500	10%
$541,501	and up	0%

Household Size		9
Income Range		Discount
$0	$119,300	100%
$119,301	$178,950	90%
$178,951	$238,600	80%
$238,601	$298,250	70%
$298,251	$357,900	60%
$357,901	$417,550	50%
$417,551	$477,200	40%
$477,201	$536,850	30%
$536,851	$566,675	20%
$566,676	$596,500	10%
$596,501	and up	0%

Household Size		10
Income Range		Discount
$0	$130,300	100%
$130,301	$195,450	90%
$195,451	$260,600	80%
$260,601	$325,750	70%
$325,751	$390,900	60%
$390,901	$456,050	50%
$456,051	$521,200	40%
$521,201	$586,350	30%
$586,351	$618,925	20%
$618,926	$651,500	10%
$651,501	and up	0%

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