



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	
Please provide the income for each of the following persons in your household (if applicable).	
<b>Circle one</b>	
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:

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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](mailto:FamilyServicesCounselors@tsrh.org)

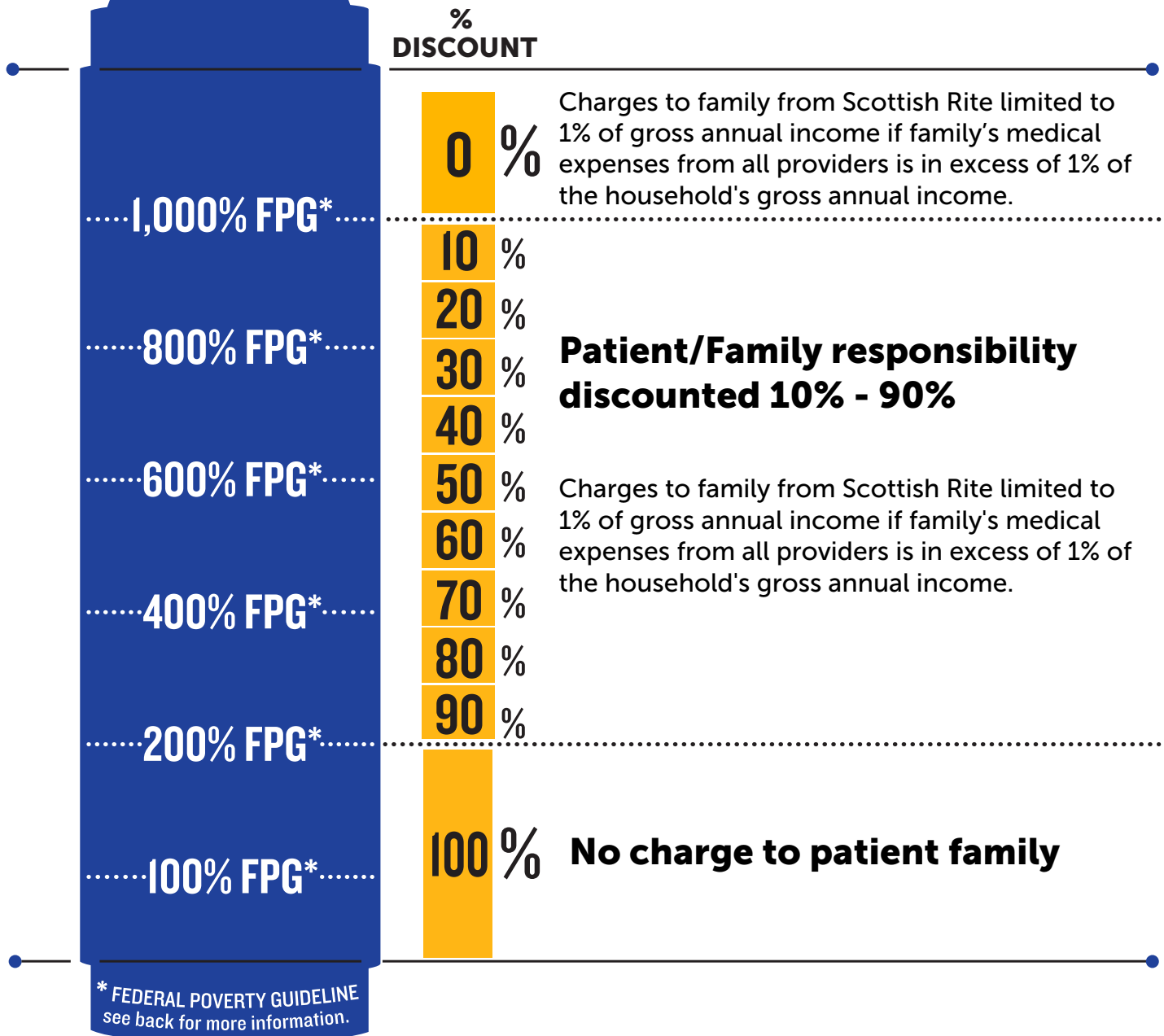
If you have any questions about your account, please call our Family Service Counselors at 214-559-8630





# 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

2021 Federal Poverty Guidelines as established by the Department of Health & Human Services  
\$21,960 Federal Poverty Limit for a household of three dependents

Household Size		3 or less
Income Range		Discount
\$0	\$43,920	100%
\$43,921	\$65,880	90%
\$65,881	\$87,840	80%
\$87,841	\$109,800	70%
\$109,801	\$131,760	60%
\$131,761	\$153,720	50%
\$153,721	\$175,680	40%
\$175,681	\$197,640	30%
\$197,641	\$208,620	20%
\$208,621	\$219,600	10%
\$219,601	and up	0%

Household Size		4
Income Range		Discount
\$0	\$53,000	100%
\$53,001	\$79,500	90%
\$79,501	\$106,000	80%
\$106,001	\$132,500	70%
\$132,501	\$159,000	60%
\$159,001	\$185,500	50%
\$185,501	\$212,000	40%
\$212,001	\$238,500	30%
\$238,501	\$251,750	20%
\$251,751	\$265,000	10%
\$265,001	and up	0%

Household Size		5
Income Range		Discount
\$0	\$62,080	100%
\$62,081	\$93,120	90%
\$93,121	\$124,160	80%
\$124,161	\$155,200	70%
\$155,201	\$186,240	60%
\$186,241	\$217,280	50%
\$217,281	\$248,320	40%
\$248,321	\$279,360	30%
\$279,361	\$294,880	20%
\$294,881	\$310,400	10%
\$310,401	and up	0%

Household Size		6
Income Range		Discount
\$0	\$71,160	100%
\$71,161	\$106,740	90%
\$106,741	\$142,320	80%
\$142,321	\$177,900	70%
\$177,901	\$213,480	60%
\$213,481	\$249,060	50%
\$249,061	\$284,640	40%
\$284,641	\$320,220	30%
\$320,221	\$338,010	20%
\$338,011	\$355,800	10%
\$355,801	and up	0%

Household Size		7
Income Range		Discount
\$0	\$80,240	100%
\$80,241	\$120,360	90%
\$120,361	\$160,480	80%
\$160,481	\$200,600	70%
\$200,601	\$240,720	60%
\$240,721	\$280,840	50%
\$280,841	\$320,960	40%
\$320,961	\$361,080	30%
\$361,081	\$381,140	20%
\$381,141	\$401,200	10%
\$401,201	and up	0%

Household Size		8
Income Range		Discount
\$0	\$89,320	100%
\$89,321	\$133,980	90%
\$133,981	\$178,640	80%
\$178,641	\$223,300	70%
\$223,301	\$267,960	60%
\$267,961	\$312,620	50%
\$312,621	\$357,280	40%
\$357,281	\$401,940	30%
\$401,941	\$424,270	20%
\$424,271	\$446,600	10%
\$446,601	and up	0%

Household Size		9
Income Range		Discount
\$0	\$98,400	100%
\$98,401	\$147,600	90%
\$147,601	\$196,800	80%
\$196,801	\$246,000	70%
\$246,001	\$295,200	60%
\$295,201	\$344,400	50%
\$344,401	\$393,600	40%
\$393,601	\$442,800	30%
\$442,801	\$467,400	20%
\$467,401	\$492,000	10%
\$492,001	and up	0%

Household Size		10
Income Range		Discount
\$0	\$107,480	100%
\$107,481	\$161,220	90%
\$161,221	\$214,960	80%
\$214,961	\$268,700	70%
\$268,701	\$322,440	60%
\$322,441	\$376,180	50%
\$376,181	\$429,920	40%
\$429,921	\$483,660	30%
\$483,661	\$510,530	20%
\$510,531	\$537,400	10%
\$537,401	and up	0%

# SCOTTISH RITE

