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 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

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% DISCOUNT	
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 %	**Patient/Family responsibility discounted 10% - 90%**
20 %	
30 %	
40 %	
50 %	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.
60 %	
70 %	
80 %	
90 %	
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

2023 Federal Poverty Guidelines as established by the Department of Health & Human Services
$24,860 Federal Poverty Limit for a household of three dependents

Household Size		3 or less
Income Range		Discount
$0	$49,720	100%
$49,721	$74,580	90%
$74,581	$99,440	80%
$99,441	$124,300	70%
$124,301	$149,160	60%
$149,161	$174,020	50%
$174,021	$198,880	40%
$198,881	$223,740	30%
$223,741	$236,170	20%
$236,171	$248,600	10%
$248,601	and up	0%

Household Size		4
Income Range		Discount
$0	$60,000	100%
$60,001	$90,000	90%
$90,001	$120,000	80%
$120,001	$150,000	70%
$150,001	$180,000	60%
$180,001	$210,000	50%
$210,001	$240,000	40%
$240,001	$270,000	30%
$270,001	$285,000	20%
$285,001	$300,000	10%
$300,001	and up	0%

Household Size		5
Income Range		Discount
$0	$70,280	100%
$70,281	$105,420	90%
$105,421	$140,560	80%
$140,561	$175,700	70%
$175,701	$210,840	60%
$210,841	$245,980	50%
$245,981	$281,120	40%
$281,121	$316,260	30%
$316,261	$333,830	20%
$333,831	$351,400	10%
$351,401	and up	0%

Household Size		6
Income Range		Discount
$0	$80,560	100%
$80,561	$120,840	90%
$120,841	$161,120	80%
$161,121	$201,400	70%
$201,401	$241,680	60%
$241,681	$281,960	50%
$281,961	$322,240	40%
$322,241	$362,520	30%
$362,521	$382,660	20%
$382,661	$402,800	10%
$402,801	and up	0%

Household Size		7
Income Range		Discount
$0	$90,840	100%
$90,841	$136,260	90%
$136,261	$181,680	80%
$181,681	$227,100	70%
$227,101	$272,520	60%
$272,521	$317,940	50%
$317,941	$363,360	40%
$363,361	$408,780	30%
$408,781	$431,490	20%
$431,491	$454,200	10%
$454,201	and up	0%

Household Size		8
Income Range		Discount
$0	$101,120	100%
$101,121	$151,680	90%
$151,681	$202,240	80%
$202,241	$252,800	70%
$252,801	$303,360	60%
$303,361	$353,920	50%
$353,921	$404,480	40%
$404,481	$455,040	30%
$455,041	$480,320	20%
$480,321	$505,600	10%
$505,601	and up	0%

Household Size		9
Income Range		Discount
$0	$111,400	100%
$111,401	$167,100	90%
$167,101	$222,800	80%
$222,801	$278,500	70%
$278,501	$334,200	60%
$334,201	$389,900	50%
$389,901	$445,600	40%
$445,601	$501,300	30%
$501,301	$529,150	20%
$529,151	$557,000	10%
$557,001	and up	0%

Household Size		10
Income Range		Discount
$0	$121,680	100%
$121,681	$182,520	90%
$182,521	$243,360	80%
$243,361	$304,200	70%
$304,201	$365,040	60%
$365,041	$425,880	50%
$425,881	$486,720	40%
$486,721	$547,560	30%
$547,561	$577,980	20%
$577,981	$608,400	10%
$608,401	and up	0%

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