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Child and Family Application

Application Requirements & Procedures:

- A separate application is required for each child/applicant seeking assistance.
- The child/applicant must be a resident of Texas.
- The child/applicant must have an identified need (pertinent information concerning the need must be attached).
- An application must be completed by the responsible legal guardian or persons seeking services.
- An Application must include **ONE** of the following proofs of income from all parties within the home:
 - ◆ Two most recent paycheck stubs, SSI benefit summary, unemployment benefit check stub, etc.
 - ◆ Most recent income tax return
 - ◆ Letter from employer (or most recent employer to verify unemployment)
- Do not leave sections blank. Sections that are not applicable please designate as N/A.
- A Provider Referral Form or letter of referral must be attached, when applicable.
- Only completed applications are reviewed and processed.

General Information:

- Masonic affiliation is given priority.
- Determination of assistance is not based on gender, religious, racial or ethnic backgrounds.
- The child/applicant and/or legal guardian/s must actively and positively participate in the treatment and resolution of their case to remain eligible for services.
- The child/applicant and/or legal guardian/s are at liberty to refuse services at anytime.
- The child/applicant and/or legal guardian/s must agree to fill out required surveys/feedback on services received.
- Masonic Children & Family Services of Texas (MCFS) considers family expenditures including special circumstance in determining services.
- If other resources are available, they are considered when making a decision regarding application approval.
- Financial support is not guaranteed and is contingent upon eligibility, availability of funds, and a qualified provider.
- MCFS may refuse support/services at any time, should staff determine that MCFS is no longer able to support/services for the child/applicant.
- The ultimate determination will be by MCFS, a program of Masonic Home and School of Texas, in its sole discretion.

Application for Child and Family Services

To be completed by applicant or legal guardian (please print):

1 **Child/Applicant's name** _____ Male Female
Last First Middle Suffix (Jr. Sr. Etc.)

Child/Applicant's address _____
Street Apt #

City State County ZIP

Date of birth ____/____/____ *Mo Day Yr* Age ____ Grade ____ Home phone (____) _____ Alt. phone (____) _____

Ethnicity: Caucasian African American Hispanic Asian/Pacific Islander Other: _____

2 **Parent/Legal Guardian Information** (If applicant is a minor, please complete the following information):

The child's/applicant's parents/legal guardians are: Single Married Divorced Widowed Separated

Mother's name/Legal Guardian's name _____
Last First Middle Suffix (Jr. Sr. Etc.)

Address _____
Street Apt #

City State County ZIP

Home phone (____) _____ Cell phone (____) _____ Work phone (____) _____

Father's name/Legal Guardian's name _____
Last First Middle Suffix (Jr. Sr. Etc.)

Address _____
Street Apt #

City State County ZIP

Home phone (____) _____ Cell phone (____) _____ Work phone (____) _____

3 What services are you requesting for the Child/Applicant? **List in Order of Importance:**

1. _____ 3. _____

2. _____ 4. _____

4 Why are you requesting these services? _____

5 What steps have you taken to remedy your current situation? _____

6 Are there any other **CHILDREN** living in this household? No Yes (If Yes, complete information below)

_____	_____	_____	_____
Child's Last Name	First Name	Middle Name	Suffix (Jr. Sr., etc)
_____	_____	_____	_____
Date of Birth	Age	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female
			Relationship to Applicant

_____	_____	_____	_____
Child's Last Name	First Name	Middle Name	Suffix (Jr. Sr., etc)
_____	_____	_____	_____
Date of Birth	Age	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female
			Relationship to Applicant

_____	_____	_____	_____
Child's Last Name	First Name	Middle Name	Suffix (Jr. Sr., etc)
_____	_____	_____	_____
Date of Birth	Age	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female
			Relationship to Applicant

_____	_____	_____	_____
Child's Last Name	First Name	Middle Name	Suffix (Jr. Sr., etc)
_____	_____	_____	_____
Date of Birth	Age	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female
			Relationship to Applicant

_____	_____	_____	_____
Child's Last Name	First Name	Middle Name	Suffix (Jr. Sr., etc)
_____	_____	_____	_____
Date of Birth	Age	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female
			Relationship to Applicant

_____	_____	_____	_____
Child's Last Name	First Name	Middle Name	Suffix (Jr. Sr., etc)
_____	_____	_____	_____
Date of Birth	Age	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female
			Relationship to Applicant

7 Are there any other **ADULTS** living in this household? No Yes (If Yes, complete information below)

_____	_____	_____	_____
Adult's Last Name	First Name	Middle Name	Suffix (Jr. Sr., etc)
_____	_____	_____	_____
Place of Employment	Monthly Income	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female
			Relationship to Applicant

_____	_____	_____	_____
Adult's Last Name	First Name	Middle Name	Suffix (Jr. Sr., etc)
_____	_____	_____	_____
Place of Employment	Monthly Income	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female
			Relationship to Applicant

8 Please list the family's monthly obligations:

Monthly Payment

Rent/Mortgage Payment	\$ _____
House Insurance	\$ _____
Electric/Gas	\$ _____
Water	\$ _____
Food/Groceries	\$ _____
Home Phone	\$ _____
Cell Phone/Pager	\$ _____
Car Payment	\$ _____
Gasoline	\$ _____
Car Insurance	\$ _____
Child Care	\$ _____
Health Insurance	\$ _____
Medical Bills	\$ _____
Major Credit Cards (Total Balance: \$ _____)	\$ _____
Loans (Total Balance: \$ _____)	\$ _____
Other (Please Specify): _____	\$ _____
Other (Please Specify): _____	\$ _____

9 Does the child/applicant/parent/guardian have income or financial support? If yes, please list below.

Child Support	<input type="checkbox"/> No <input type="checkbox"/> Yes	Monthly Amount: \$ _____
TANF	<input type="checkbox"/> No <input type="checkbox"/> Yes	Monthly Amount: \$ _____
Housing	<input type="checkbox"/> No <input type="checkbox"/> Yes	Monthly Amount: \$ _____
WIC	<input type="checkbox"/> No <input type="checkbox"/> Yes	Monthly Amount: \$ _____
Food Stamps	<input type="checkbox"/> No <input type="checkbox"/> Yes	Monthly Amount: \$ _____
Social Security (Retirement or SSI/SSD)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Monthly Amount: \$ _____
Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Monthly Amount: \$ _____

10 Do the parents/legal guardians work?

Mother/Legal guardian: No Yes _____ Monthly Amount: \$ _____

Employer Name

* If **mother** is unemployed, what is the reason and length of time? _____

Father/Legal guardian: No Yes _____ Monthly Amount: \$ _____

Employer Name

* If **father** is unemployed, what is the reason and length of time? _____

11 Please check the type of health coverage that applies to the child/applicant:

No coverage Medicaid CHIP CSHCN Other Heath/Dental Coverage: _____

12 Masonic Affiliation: Yes No If yes, Mason's Name: _____

Father Grandfather Great-grandfather Uncle Other _____

Masonic Lodge Name & No.: _____

13 How did you hear about Masonic Children & Family Services of Texas? (Specific name of agency, friend or relative):

14 ***I acknowledge that Masonic Children & Family Services of Texas (MCFS) will rely on the information in this application while making its decisions on this request. I authorize MCFS to consult with, or release information to any person whom they deem necessary to verify this information and the request. I understand it is sometimes necessary for MCFS to do this in order to make its decision on my request. This authorization expires one year from the date below.***

Signature: _____ Date: _____

Child's/Applicant's Parent/Legal Guardian

15 If someone other than the person signing above filled out this application, please complete the following:

Name

Relationship to Applicant

Agency and/or Title

Phone

Address

City, State, Zip

16 Recommendation by a Texas Master Mason **NOTE: Application may be submitted without this signature if no Mason was involved in the referral.**

Date *Print Name* *Signature*

Lodge Name *Lodge Number*



A PROGRAM OF:

MASONIC HOME AND SCHOOL OF TEXAS



**AUTHORIZATION TO RELEASE MEDICAL INFORMATION
(HIPAA AUTHORIZATION UNDER 45 C.F.R. § 164.508)
CHILD**

STATEMENT OF INTENT

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), that there are federal regulations that interpret and implement that law, and that HIPAA limits disclosure of my child's Individually Identifiable Health Information to certain of my family and friends, regardless of my child's state of health. I am signing this authorization so my child's Health Care Providers can disclose my child's health care information to the persons listed below, and openly discuss that information with them.

AUTHORIZATION

I, _____, am the parent, guardian or managing conservator of _____ ("my child"). I hereby authorize my child's physicians, nurses, hospitals and other Health Care Providers to fully disclose my child's Individually Identifiable Health Information to the Masonic Home and School of Texas d/b/a Masonic Children & Family Services of Texas, 338 Grapevine Hwy., Hurst, TX 76054, 817-503-1500 (my child's "Personal Representatives").

AUTHORITY TO DISCUSS AND ANSWER QUESTIONS

My child's Health Care Providers are expressly authorized to answer questions posed by the Personal Representatives listed above and openly discuss with them my child's condition, treatment, test results, prognosis, and everything pertinent to my child's health care, even if I am fully competent to ask questions and discuss this matter at the time. This document constitutes a full authorization to disclose ANY of my child's Individually Identifiable Health Information to the Personal Representatives named in this Authorization.

WAIVER AND RELEASE

I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Information and for any actions taken by my child's Personal Representatives.

TERMINATION

This Authorization is effective as of the date shown as the date of its signing, and shall not be affected by my subsequent disability or incapacity. This authorization shall terminate on this first to occur of: (1) two years following my child's death or (2) upon my written revocation actually received by the Health Care Provider, proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the Health Care Provider.

RE-DISCLOSURE

By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Personal Representatives named in this Authorization and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me or my child embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I fully indemnify my child's Health Care Providers for all consequences which may occur as a result of their good faith reliance and compliance with this Authorization. No Health Care Provider shall require my child's Personal Representatives to indemnify the Health Care Provider or agree to perform any act in order for the Health Care Provider to comply with this Authorization.

ENFORCEMENT

My child's Personal Representatives shall have the right to bring a legal action in any applicable forms against any Health Care Provider that refuses to recognize and accept this Authorization. Additionally, my child's Personal Representatives are authorized to sign any documents that my child's Personal Representatives deem necessary or appropriate to obtain my child's Individually Identifiable Health Information.

CONFLICTS WITH OTHER AUTHORIZATIONS

This Authorization is in addition to other medical release authorizations I may have granted in the past or future. It does not replace them. This Authorization may be relied upon by my child's Health Care Providers regardless of any real or perceived conflict with any Medical Power of Attorney signed by me, whether prior to or subsequent to the date of this Authorization. I recognize and intend that this will result in multiple persons having the authority to obtain my child's protected Individually Identifiable Health Information. This Authorization is not intended to replace a Medical Power of Attorney, nor to grant any person the authority to make health care decisions, but merely to obtain information and explanations.

COPIES

A copy or facsimile of this original Authorization may be accepted and relied upon as though it was an original document.

DEFINITIONS

The term "Individually Identifiable Health Information" includes (but is not limited to) the following:

All health care information, reports and/or records concerning my child's medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identify of health care providers and insurers, whether past, present or future and any other medical information which is in any way related to my child's health care. In this Authorization, the term also includes the term "Protected Medical Information," as sometimes used in HIPAA.

The term "Health Care Providers" includes (but is not limited to) the following:

Doctors (including but not limited to physicians, podiatrists, chiropractors, and osteopaths), psychiatrists, psychologists, dentists, therapists, nurses, hospitals, clinics, pharmacies, laboratories, ambulance services, assisted living facilities, residential care facilities, bed and board facilities, nursing homes, medical insurance companies or any other medical providers, or affiliates. In this Authorization, the term also includes the term "Covered Entity," as sometimes used in HIPAA.

SIGNED on _____, 20____, at _____ County, Texas.

Parent, Guardian or Managing Conservator

THE STATE OF TEXAS §
 §
COUNTY OF §

This document was acknowledged before me on _____, 20____, by _____.

NOTARY PUBLIC, STATE OF TEXAS

This form must be notarized in order for application to be considered complete.