**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 | Portland | 3101 S.W. Sam Jackson Park Road  
|                 |         | Portland, OR 97201-5090  
| * Chicago       |         | 503-241-5090  
|                 | Salt Lake City | Fairfax Road at Virginia Street  
|                 |         | Salt Lake City, UT 84103  
|                 |         | 801-536-3500  
| Erie            | Shreveport | 3100 Samford Ave.  
|                 |         | Shreveport, LA 71103  
|                 |         | 318-222-5704  
| Greenville      | Spokane | 911 W. Fifth Ave.  
|                 |         | Spokane, WA 99204-2901  
|                 |         | 509-455-7844  
| Honolulu        | Springfield | 516 Carew St.  
|                 |         | Springfield, MA 01104  
|                 |         | 413-787-2000  
| Houston         | St. Louis | 2001 S. Lindbergh Blvd.  
|                 |         | St. Louis, MO 63131-3597  
|                 |         | 314-432-3600  
| Lexington       | Tampa | 12502 North Pine Dr.  
|                 |         | Tampa, FL 33612-9499  
|                 |         | 813-972-2250  
| Los Angeles     |         | 3106 Geneva St.  
|                 |         | Los Angeles, CA 90020  
|                 |         | 213-388-3151  
| Mexico City     |         | 3160 Geneva St.  
|                 |         | Los Angeles, CA 90020  
|                 |         | 213-388-3151  
| Minneapolis     |         | 2111 N. Oak Park Ave.  
|                 |         | Chicago, IL 60707  
|                 |         | 773-622-5400  
| * Philadelphia  |         | 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     |         | 3160 Geneva St.  
|                 |         | Los Angeles, CA 90020  
|                 |         | 213-388-3151  
| 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  
| *Sacramento     |         | 2425 Stockton Blvd.  
|                 |         | Sacramento, CA 95817  
|                 |         | 916-453-2000  

*BURN CARE*

<p>| | | | |</p>
<table>
<thead>
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<th></th>
</tr>
</thead>
</table>
| 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**

| *Philadelphia |      | 3551 North Broad Street  
|               |      | Philadelphia, PA 19140  
| *Sacramento   |      | 2425 Stockton Blvd.  
|               |      | Sacramento, CA 95817  
|               |      | 916-453-2000  

*Includes Spinal Cord Injury Rehabilitation Center
# Application Form

**Shriners Hospitals for Children**

This form is to be completed by the parent or guardian of the child.

## Name of Child

<table>
<thead>
<tr>
<th>(Last)</th>
<th>(First)</th>
<th>(Middle)</th>
</tr>
</thead>
</table>

**Permanent Home Address:**

<table>
<thead>
<tr>
<th>(Street)</th>
<th>(City/Town)</th>
<th>(County)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(State/Province)</td>
<td>(Zip Code)</td>
<td>(Country)</td>
</tr>
</tbody>
</table>

**Mailing Address:**

<table>
<thead>
<tr>
<th>(If different)</th>
<th>(Street)</th>
<th>(City/Town)</th>
<th>(County)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(State/Province)</td>
<td>(Zip Code)</td>
<td>(Country)</td>
<td></td>
</tr>
</tbody>
</table>

**Home #:**

<table>
<thead>
<tr>
<th>(Area Code)</th>
<th>(Phone Number)</th>
<th>Alternate #</th>
<th>(Area Code)</th>
<th>(Phone Number)</th>
</tr>
</thead>
</table>

**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

<table>
<thead>
<tr>
<th>(Last)</th>
<th>(First)</th>
<th>(Middle)</th>
<th>(Maiden)</th>
</tr>
</thead>
</table>

**Address:**

<table>
<thead>
<tr>
<th>(Street)</th>
<th>(City/Town)</th>
<th>(County)</th>
<th>(State/Province)</th>
<th>(Zip)</th>
</tr>
</thead>
</table>

**Home #:**

<table>
<thead>
<tr>
<th>(Area Code)</th>
<th>(Phone Number)</th>
<th>Work #</th>
<th>(Area Code)</th>
<th>(Phone Number)</th>
</tr>
</thead>
</table>

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

## Name of Father

<table>
<thead>
<tr>
<th>(Last)</th>
<th>(First)</th>
<th>(Middle)</th>
</tr>
</thead>
</table>

**Address:**

<table>
<thead>
<tr>
<th>(If different From Mother)</th>
<th>(Street)</th>
<th>(City/Town)</th>
<th>(County)</th>
<th>(State/Province)</th>
<th>(Zip)</th>
</tr>
</thead>
</table>

**Home #:**

<table>
<thead>
<tr>
<th>(Area Code)</th>
<th>(Phone Number)</th>
<th>Work #</th>
<th>(Area Code)</th>
<th>(Phone Number)</th>
</tr>
</thead>
</table>

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

## Name of Legal Guardian:

<table>
<thead>
<tr>
<th>(If different From Above)</th>
<th>(Last)</th>
<th>(First)</th>
<th>(Middle)</th>
</tr>
</thead>
</table>

**Relationship to child:**

**Address:**

<table>
<thead>
<tr>
<th>(Street)</th>
<th>(City/Town)</th>
<th>(County)</th>
<th>(State/Province)</th>
<th>(Zip)</th>
</tr>
</thead>
</table>

**Home #:**

<table>
<thead>
<tr>
<th>(Area Code)</th>
<th>(Phone Number)</th>
<th>Work #</th>
<th>(Area Code)</th>
<th>(Phone Number)</th>
</tr>
</thead>
</table>

(continued on reverse)

---

**SPONSORING SHRINER INFORMATION**

**Sponsoring Shriner’s Temple:**

**Shriner’s Name:**

**Shriner’s Address:**

<table>
<thead>
<tr>
<th>(Street)</th>
<th>(City/Town)</th>
<th>(State/Province)</th>
<th>(Zip)</th>
</tr>
</thead>
</table>

**Daytime Phone:** (Area Code) (Number)

**Sponsoring Shriner’s Signature**

---

**FOR HOSPITAL USE ONLY:**

**Return To:**

<table>
<thead>
<tr>
<th>Hospital</th>
</tr>
</thead>
</table>

**Address:**

| ____________________________ |

**Application Number:**

| ____________________________ |

**Date of Screening Visit:**

| ____________________________ |

**Medical Record Number:**

| ____________________________ |

**Name of Person Initiating Form:**

---

[Form 1036 Rev 9/98](http://www.shrinershq.org)
## MEDICAL INFORMATION

**Problem or Diagnosis (if known):**

**Date First Noticed:**

**Chief complaint (symptom) describe:**

**How long has the child had the problem:**

**Injury:**

**Date:**

**What other symptoms does your child have (describe):**

### Currently Under Care of: 

<table>
<thead>
<tr>
<th>Physician</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone #:</td>
<td></td>
</tr>
</tbody>
</table>

### Treatment Provided:

**Surgery/Dates:**

**Other treatment/Dates:**

**X-rays:**

**Date of most recent X-ray:**

**When was child last seen by doctor:**

**Has child been treated at another Shriners Hospital:**

**Date of treatment:**

**Location/City:**

## FINANCIAL INFORMATION

**Total combined family income for last 12 months:**

- $1–$10,000
- $10,000–$20,000
- $20,000–$30,000
- $30,000–40,000
- $40,000–$50,000
- 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
- Overage
- Other

**Reason for Non-Compliance Foreign Patient Policy**

**Signature**

**Date**

---

*Form 1036 Rev 10/98*