Clara B. Farlow Foundation for Children Application for Benefits

This application is for payment of medical expenses for children and teens under age 18. Children may fill out the application which will need to be signed by parent or guardian. If you have questions or would like help completing this form, phone 336-786-8936. We'll be happy to help you.

Please print in black or blue ink. Do not use pencil.

List a parent or guardian who will receive follow-up information.

1.	FIRST NAME	MIDDLE IN	MIDDLE INITIAL		LAST NAME	
2.	ADDRESS WHERE YOU LIV	E STREET	CITY	STATE	ZIP CODE	
3.	MAILING ADDRESS (IF DIFF	FERENT)	CITY	STATE	ZIP CODE	
1.	TELEPHONE NUMBERS: HOME () WORK () OTHER ()					
5.	Do you have trouble speaking, reading, or writing English? If "YES," what language or alternative format do you need?			YES		
5.	Do you need an interpreter?			YES	N	
	If "YES," what language do you	u speak?				
7.	Please give the name of the child under age 18 who has a serious physical and/or mental illness.					
	Name of child:		Age of	Child		
	MaleFema	ıle				
	Briefly describe the serious phy					
	Name and phone number of the					

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Name (FIRST, MIDDLE, LAST) Parent Or Guardian:	SEX RELATION TO YOU	BIRTH DATE	PLACE OF BIRTH	US CITIZEN YES NO
Spouse:				
Date child arrived in U Does child have a spo	U.S. ensor?	YES	NO	
Does child have a spo	U.S. ensor?	YES	NO	
Date child arrived in U Does child have a spo List Other Adults In the House	U.S. onsor? hold:			NO
Date child arrived in U Does child have a spo List Other Adults In the House D. Is any child under age 18,	U.S. pnsor? hold: in your household, di	sabled?		
Date child arrived in U Does child have a spo List Other Adults In the House D. Is any child under age 18,	U.S. pnsor? hold: in your household, di	sabled?	YESN	
Date child arrived in U Does child have a spo List Other Adults In the House D. Is any child under age 18, If "YES," who?	J.S. pnsor? hold: in your household, di for childcare when en	sabled? Age	YESN	

Income			
Parent/Guardian Employer Name and	Telephone Number:		
Employer Name and Telephone Number of Pa	nrent/Guardian completing	this application:	
Income this parent/guardian received in the (Please provide a copy of last four payches).	eck stubs).	s and other withholding:	
Employer Name and Telephone Number of O	ther Parent /Guardian Livi	ng in Same Household:	
14. Income received by other parent/guardian (Please provide a copy of last four payches)	eck stubs).	taxes and other withholding:	
15. Monthly Child Support Received: \$			
16. Monthly Alimony Received: \$			
17. Monthly Social Security Payments Received			
18. Monthly Unemployment Benefits Receive			
19. Monthly Military Allotments Received: \$			
20. Other Monthly Income Received: \$			
21. Do you need help paying medical bills for	r any child in the househol	d? YES NO	
If "YES," how much are these outstarting if "YES" please provide copy of med		\$	
22. Does any child in the household have hea	lth insurance? YES	NO	
If "YES," provide the following:			
Name of Insurance Company	Policy Number	Name of Child	
Please provide copy of insurance card(s)			
Declaration and Signature: I have read and un perjury, that the information I have given is true			
SIGNATURE OF PARENT/GUARDIAN:		DATE:	

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize the use and disclosure of protected health information for my child/dependent:

Print NAME OF CHILD who has applied to receive financial assistance from The Clara B. Farlow Foundation

Protected health information is individually identifiable health information, including demographic information, collected or created or received by a health care provider, a health plan, employer, or a health care clearinghouse and that relates to: (i) past, present, or future physical or mental health or condition; (ii) the provision of health care; or (iii) the past, present, or future payment for the provision of health care.

The following individuals and/or organizations are authorized to disclose the protected health information: (Please list names and phone number of physicians, hospitals and/or medical service providers who have provided medical services to child/dependent named above who is requesting assistance from The Clara B. Farlow Foundation.)

Physician Name	Physician Name	Physician Na	ame
Physician Phone Number	Physician Phone Number	Physician Ph	none Number
Insurance Company Name	Med	lical Service Provider Name	
Insurance Company Phone Number	Med	lical Service Provider Phone	Number
Name of Policy Holder for Insurance Company	Wel	fare Program	
Insurance Company Policy Number	Wel	fare Program Phone Number	
The following organization is authorized Foundation.	1 to receive my prot	ected health information	n: The Clara B. Farlow
The protected health information that may	be used and disclose	d is as follows:	
The protected health information will be financial assistance from the Foundation to for child/dependent named above. Plea information, dates of service and claim child/dependent named above.	o pay medical bills re ase disclose informa	lated to the serious physition such as type of	ical and/or mental illness illness, prognosis, claim
I understand that if the protected health in health care providers, health care clearin protected health information described ab regulations.	ghouses, or health p	lans covered by federal	privacy regulations, the
I understand that I may revoke this author Farlow Foundation and/or the physicians, revocation will be effective for future use understand that this revocation will not be used or disclosed, relying on this author coverage in my group health plan and, by I	medical service proves and disclosures of the effective: (i) for intrization or (ii) if the	riders and insurance con protected health informa- formation that my group authorization was obta	npany listed above. This ation. However, I further p health plan already has ained as a condition for
I AUTHORIZE THE REIMBURSEMEN CLARA B. FARLOW FOUNDATION TO	T OF OVERPAYME O BE PAID BACK TO	NT OF FUNDS PAID T O THE CLARA B. FAR	O PROVIDER BY THE LOW FOUNDATION.
Signature of Parent or Guardian		Date	

PRINT the name of Parent or Guardian