



MISSOURI CHAPTER

P.O. Box 9227, St. Louis, MO 63117 · (314) 781-0244

**MISSOURI KIDS PROGRAM
APPLICATION FOR ASSISTANCE**

This application must be filled out by the child's family and returned to the Healing the Children office along with a written request from the child's case manager, doctor or hospital.

"MANKIND OWES TO THE CHILD THE BEST IT HAS TO GIVE."



**Healing
the
Children®**

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**MISSOURI KIDS PROGRAM - APPLICATION FOR ASSISTANCE
Child's Statistics – Part 1 of 2 Parts**

Child's Name: _____ SS No. _____

Age: _____ Date of Birth: _____ Gender (Sex): _____

Nationality: _____ Birthplace: _____

Address: _____
Street City State Zip Code

Mother/Father/Guardian's Name: _____
(circle one)

Home Phone: _____ Work Phone: _____

Medical Problem: _____

(Attach medical report if additional space required)

Referring Agency: _____

Contact Person: _____ Phone: _____

Address: _____
Street City State Zip Code

Type of Assistance Requested:

1. Financial: Amount Requested: _____ Received: _____
(HTC use only)

2. Specialized Equipment: Type: _____

Cost: _____

Vendor: Name: _____

Address: _____

Contact: _____ Telephone: _____

Child's Name _____

3. Prescriptions/Over the Counter Medications: (circle one)

Type: _____ Cost: _____
_____ per _____
_____ month _____

Pharmacy: _____

Address: _____
Street City State Zip Code

Contact Person: _____ Telephone: _____

4. Transportation:

To: _____

From: _____

Cost: _____

5. Other: (Explain) _____

Request Date: _____

For HTC Use Only:

Date Assistance Began: _____ Date Ended: _____

Child's Name: _____

MISSOURI KIDS PROGRAM - APPLICATION FOR ASSISTANCE
Family Statistics – Part 2 of 2 Parts

Mother's Name: _____ SS No. _____

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____

U.S. Citizen: Yes: _____ No: _____ (If no, fill in below)
Resident Status: Permanent Resident: _____ Temporary Resident: _____
Visitor's Visa: _____ Tourist Visa: _____
Do you have a Green Card? Yes: _____ No: _____

Father's Name: _____ SS No. _____

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____

U.S. Citizen: Yes: _____ No: _____ (If no, fill in below)
Resident Status: Permanent Resident: _____ Temporary Resident: _____
Visitor's Visa: _____ Tourist Visa: _____
Do you have a Green Card? Yes: _____ No: _____

Employment Status:

Mother: Employer: _____

Salary/Wages/Annual Income: _____ Position: _____

Father: Employer: _____

Salary/Wages/Annual Income: _____ Position: _____

Number of Children in family: _____ Number of Adults in Family: _____

Housing: Do you own your own home? Yes _____ No _____

Do others besides Parents/Guardian contribute to the support of the child for whom assistance is being requested? Yes _____ No _____

If answer is yes to this question, to what extent do others contribute: _____

Child's Name: _____

Medical Coverage:

Medicaid/SSI: Yes _____ No _____
Private Insurance: Yes _____ No _____

If yes, name of insurance company/plan: _____

Additional information applicant wishes to convey: _____

IMPORTANT: This section must be completed:

Healing the Children Missouri requests that the parent(s)/guardian of this child supply a picture of said child and authorize HTC to use this picture, along with the child's FIRST name, in our newsletters and publications.

Authorization given _____
Authorization not given _____

Mother's Signature: _____ Date: _____

Father's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Please return completed application to: Healing the Children
P.O. Box 9227
St. Louis, MO 63117

Feel free to contact us with any questions.
Phone # 314-781-0244
E-mail: htcmo@swbell.net