THE CAPEN FUND FOR KIDS
CHILDREN'S MEDICAL ASSISTANCE

Please complete this application so we may process your request. All fields are required.

Name of Child ____

Date of Birth ________________________ Attending School _________________________________

Name of Parent or Guardian ____

Address ____

Street City, State Zip County

Telephone_________________________ # of Dependents (including Parents) _____

Household Income ________________ [ ] per month [ ] per year

** ATTACH A COPY OF PROOF OF INCOME (PAYSTUBS, DISABLIILTY, TAX FORMS**

What this child needs & why (Please be specific as possible):

____

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Please check any other resources from whom you have requested assistance:

___Florida Kid Care

___Medicaid –HRS

___Children Medical Service of St. Lucie County

___Florida Community Health Services in Indiantown

___Martin/St. Lucie County Public Health

___Other (please specify where) ____

Reason(s) for not qualifying from any of the above:

____

____

Medical or social service professional who can verify your needs: (please provide name and phone number) ____

Applicant referred to the Capen Fund by: _____________________________________

The Capen Fund will maintain your confidentiality to the fullest extent possible. By submitting your application, you understand that we may need to contact a medical or social services professional to verify the circumstances and extent of the child's need.

I understand, and I wish the Capen Fund to evaluate this application. As requested above, I have attached the necessary documentation.

______________________ ____________________________________

Date Parent/Guardian Signature

Return Completed form to:

Capen Fund for Kids –Cleveland Clinic Martin Health Foundation

P.O. Box 9010, Stuart, FL 34995 (772) 223-5635 Fax (772) 223-5633

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

By signing below, I acknowledge that I have applied for assistance from the Capen Fund for Kids, sponsored or administered by Cleveland Clinic Martin Health System or Cleveland Clinic Martin Health Foundation.

I understand that I must meet program criteria to participate in this program. To administer the program, associates of Cleveland Clinic Martin Health or members of the Capen committee will discuss your case and may need to share your child's health information or medical records with each other and other physicians and faculties in order to plan for and pay for medical care.

1. I request and authorize the release of or access to electronic medical records held by Cleveland Clinic Martin Health Systems facilities and physicians of my child's medical record only to the extent necessary for assistance by the Capen Fund for Kids.
2. I consent to the sharing of my financial information and my child's health care information with the following:
    a. My child's current physicians, social service agencies and other healthcare professionals.
    b. Members of the committee that administer the Capen Fund for Kids.
    c. Other physicians, hospitals, healthcare providers that my child may need in the future.
3. I also authorize my child's health care providers to speak with representatives of the Capen Fund for Kids for the purpose of determining my child's current or future health care needs and if I meet the Capen Fund for Kid's criteria.

My records may contain the following and, UNLESS CROSSED OUT AND INITIALED, I specifically authorize their release: HIV Test Results (AIDS); AIDS Related Records Drug: Substance Abuse Records.

____

Signature Date

Relationship to Patient: ____

Explain and/or attach Legal Documentation

Pursuant to Florida law and Health Insurance Portability and Accountability Act of 1996 Privacy Rule, the record may be given only to the person designated, and it may be used only for the purpose listed on this form. No information may be redisclosed to any other person without the specific written consent of the undersigned. Charges are in compliance with Florida Law. I understand that signing this authorization at any time, in writing, to the address listed above provided that the information has not yet been released. This authorization expires in six (6) months unless another day is written here __________________________.