SCOTTISH RITE SPONSORSHIP APPLICATION

TO: Eugene F. Herman Scottish Rite Childhood Language Disorders Clinic, Inc. (RiteCare)

514 14th Street West
Billings, MT 59102
406-259-6683
email: secretary@billingsscottishrite.com

Instructions: Fill each blank with the requested information or "N/A" if the request does not apply.
Request for Sponsorship for speech/language therapy for:

Name of Child: _____ Date of Birth:_____

Current speech therapy: _____ _____
Clinic/School/Therapist Inclusive Dates

Prior speech therapy: _____ _____
Clinic/School/Therapist Inclusive Dates

School:_____ Grade:_____ Teacher:_____

Parent/Guardian Contact Information (Please print legibly and show phone numbers and email addresses to be used.)

_____
Father's Name Street address (apt. #) Father's email

_____
City/Town State Zip Code Father's phone#

_____
Mother's Name Street address (apt. #) Mother's email

_____
City/Town State Zip Code Mother's phone #

_____
Guardian's Name Street Address (apt. #) Guardian's email

_____
City/Town State Zip Code Guardian's phone#

Contact preference: Father Mother Either (circle one)

Clinic Information:

Name of Treating Clinic _____

Clinic email: _____ Clinic phone_____

Name of Treating Clinician_____

Clinician email: _____ Clinician phone_____

Name of Clinic Contact_____email_____phone_____

Number of dependents in household_____

Other children receiving speech/language therapy:

_____	_____	_____
Name of Child	Date of Birth	Name of Therapist/Clinician
_____	_____	_____
Name of Child	Date of Birth	Name of Therapist/Clinician

Financial Information: (Include last two years of filed Federal tax returns.)

Father: $_____ Tax Year_____ $_____ Tax Year_____
Amount Amount

Mother: $_____ Tax Year_____ $_____ Tax Year_____
Amount Amount

Child Seeking Sponsorships: Monthly Amount $_____ Name of Payee_____

Child Support: Monthly Amount $_____ Name of Payee_____

ASSETS of Applicant(s) or owned by either parent:

Approximate equity in personal residence: $_____
(Fair market value less mortgages)

Savings: $_____

Retirement Accounts: $_____

Other real property: $_____

Other Personal property: $_____
(Motor vehicles, stocks, bonds, etc.)

LIABILITIES:

Approximate normal monthly household expenses including rent/house payments, food, transportation, utilities, insurance, medical expenses, etc. $_____

Bank Debt: $_____Credit Card Debt: $_____

Other Debt: $_____

Applicant's Statement

Briefly state the speech and language problems of the child for which this application is made, your expectations for treatment and the reasons for qualifying for a Scottish Rite Sponsorship: (Attach additional page if needed)

Scottish Rite Policy and Procedure:

Scottish Rite pays according to its RITE CARE Treatment Plans for speech and language therapy which may not exceed six (6) months. Each may be renewed before it expires. Timely renewals, signed by both the parents and the treating clinician, are granted administratively through the Billings Scottish Rite office. Scottish Rite does not pay for any clinical treatment rendered during any period not actively covered by a valid, unexpired Treatment Plan. It is the policy of Scottish Rite to provide Rite Care benefits pursuant to its Treatment Plans as long as treatment is recommended by the licensed treating therapist working under a Rite Care agreement and the Rite Care charity has sufficient funds. All funding is made at the sole discretion of Scottish Rite acting through the corporate board of directors of this charity. Funding will end when the treating therapist discharges the patient, the patient reaches the age of twenty-one (21), or the parents have not complied with the terms of the Treatment Plan. The responsibility of the Scottish Rite is exclusively funding. It does not employ any medical experts or provide any medical services or advice. All communications may be made through the Scottish Rite office described above.

Consent for Treatment and Release of Protected Confidential Information:

The undersigned[s], each for his or herself, consent and agree to clinical treatment by the therapist and/or clinic that I/we have selected or consented to for the treatment of our child under the sponsorship of Scottish Rite. I/we voluntarily waive all medical and personal right of privacy to all persons involved in processing, financing, and delivering speech and language therapy with the Scottish Rite program.

_____

Signatures and Certification:

The undersigned[s] represent and warrant that the information contained in this application is true, accurate and correct to the best of his/her/their knowledge and information.

Dated this _____day of _____, 20_____.

Applicant's Signature	**Applicant's Printed Name**	**Parent or Guardian (specify)**
Applicant's Signature	**Applicant's Printed Name**	**Parent or Guardian (specify)**