SCOTTISH RITE SPONSORSHIP APPLICATION

TO: Eugene F. Herman Scottish Rite Childhood Language Disorders Clinic, Inc. (Scottish Rite) 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	Father's Address	Father's phone#	Father's email
_____	_____	_____	_____
Mother's Name	Mother's Address	Mother's phone #	Mother's email
_____	_____	_____	_____
Guardian's Name	Guardian's Address	Guardian's phone#	Guardian's email

Contact preference: Father Mother Either (circle one)

Number of dependents in household_____ **Clinic Information:**

Name of Treating Clinic_____

email_____phone_____ Name of Treating

Clinician_____email_____phone_____ Name of Clinic

Contact, if any_____ email_____phone_____ Rev. 9/1/21

Other children receiving speech/language therapy:

_____ _____
_____ Name of Child D ate of Birth
Name of Therapist/Clinician

_____ _____
_____ Name of Child D ate of Birth
Name of Therapist/Clinician

_____
____ **Applicant Information:**

_____Single ☐ Married ☐ Divorced ☐ Name of
Spouse_____ Name of applicant (Who will represent the child for speech therapy)

Applicant Contact Numbers: Work
No:_____Home:_____Cell:_____
_____
____

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

Father: $_____ Tax Year_____ $_____ Tax
Year_____ Amount Am ount

Mother: $_____ Tax Year_____ $_____ Tax
Year_____ Amount Am ount

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: $_____

INSURANCE:

1. Is there any health insurance or health plan in force covering the child for which the application is made? Yes No (circle one)

2. Does the insurance or health plan cover speech and language disorders? Yes No (circle one)

3. Does the insurance or health plan require that a deductible be met? Yes No N/A (circle one)

4. Does the Insurance or health plan require a co-pay for each clinical treatment? Yes No N/A (circle one)

5. What do the parents contribute to the premium if any, for the insurance or health plan?

$_____per _____ No insurance or plan (circle if applicable)
M o. Y r. Treatment

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)