APPLICATION TO RENEW SCOTTISH RITE SPONSORSHIP

TO: Billings Scottish Rite Children's Clinic
% Michael Welton, Secretary
514 14th Street West
Billings, Montana 59102

Name of sponsored child: _____

Parents/Guardian:
Name (s):_____
Address _____
Best phone No: _____ Alt. Phone No. _____
email:_____

Clinical provider:
Name of Agency: _____
Address: _____
Clinician: _____ Phone No. _____

1. State any significant change as to the original financial resources of the child.
(use separate sheet if needed)

2. Will there be insurance coverage for the child during the next 6 months of treatment?
If so, please describe. (use separate sheet if needed)

3. Is current level of support still needed? _____ yes _____ no

4. Current Treatment plan period:_____to_____

5. Beginning date proposed for new 6 month Treatment Plan requested_____

_____ _____
_____
Parent Date Parent Date

APPROVAL BY CLINICAL PROVIDER

Speech and/or language therapy continues to be necessary for _____sessions per week. An additional six (6) month period is recommended. I am satisfied with the cooperation of the parent(s) supporting this therapy.

_____
Clinician Date