# CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS) APPLICATION

Michigan Department of Health and Human Services

**INSTRUCTIONS:**

- Enter information in ALL sections.
- If you have any questions, please contact a CSHCS representative at your local health department, call 1-800-359-3722, or visit www.michigan.gov/cshcs.

☐ Check here if the Local Health Department helped you fill out this form.

- Keep the YELLOW copy for your records.
- Mail the WHITE copy of this form and a photocopy of each insurance card in the enclosed envelope to:

**CSHCS DIVISION**
**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**PO BOX 30734**
**LANSING MI 48909-8234** **Fax:** 517-335-9491

**PLEASE PRINT CLEARLY**

## SECTION 1 – Client Information (Adult Applicant, Minor or Dependent Child)

| | | | | |
|---|---|---|---|---|
| 1. Client Name (Last, First, Middle) | | | 2. CSHCS or Medicaid Client ID No. | 3. Date of Birth |
| 4. Client's Home Address (Number and Street, Apartment No.) | | | 5. Client's Social Security No. - - | 6. Sex ☐ MALE ☐ FEMALE |
| City | State | ZIP Code | 7. ☐ Check if Child has Died | 8. Date of Death |
| 9. County Client Lives in | | 10. U.S. Citizen? ☐ YES ☐ NO | 11. Michigan Resident? ☐ YES ☐ NO | 12. Migrant Farm Worker? ☐ YES ☐ NO |
| 13. Home Phone - - | | 14. Cell Phone - - | 15. Family Email Address | |
| 16a. Is this person adopted? | | 16b. Date of Adoption | 16c. Previous Complete Name (if different) | |

17a. IF Hispanic / Latino, ethnicity – Check One (You are not required to complete this information.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

17b. Racial / Ethnic Heritage - Check One (You are not required to complete this information.)

| | | | | |
|---|---|---|---|---|
| ☐ White | ☐ American Indian / Alaska Native | ☐ Filipino | ☐ Vietnamese | ☐ Guamanian / Chamorro |
| ☐ Black / African American | ☐ Asian Indian | ☐ Japanese | ☐ Other Asian | ☐ Samoan |
| | ☐ Chinese | ☐ Korean | ☐ Native Hawaiian | ☐ Other Pacific Islander |

## SECTION 2 – Parent, Court-Appointed Legal Guardian, or Foster Parent Information

| | | | | | |
|---|---|---|---|---|---|
| 18a. Name (Last, First, Middle) | | | 18b. Name (Last, First, Middle) | | |
| 19a. Home Address (if different from client's) | | | 19b. Home Address (if different from client's) | | |
| City | State | ZIP Code | City | State | ZIP Code |
| 20a. Daytime Phone Number ( ) - | 21a. Social Security Number - - | | 20b. Daytime Phone Number ( ) - | 21b. Social Security Number - - | |

22. Is at least one parent/court-appointed guardian a US Citizen? ☐ YES ☐ NO Michigan Resident? ☐ YES ☐ NO Migrant Farm Worker? ☐ YES ☐ NO

## SECTION 3 – Health Coverage and Insurance Information

23. Is this client receiving any of the following programs? ***(check all that apply)***

☐ MEDICAID ID#: _____
☐ MIChild
☐ MEDICARE - A Claim #: _____
☐ MEDICARE - B Claim #: _____
☐ MEDICARE - C Claim #: _____
☐ MEDICARE - D Claim #: _____

24. Are the major health problems related to an accident or birth injury?
☐ YES ☐ NO

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| 25. Other Insurance Policies that cover this client for Health, Dental, Pharmacy or Vision Care Services. | | | |
|---|---|---|---|
| **A** Name of Policy Holder | | Social Security Number - - | What type of insurance? ☐ HEALTH ☐ PHARMACY ☐ DENTAL ☐ VISION |
| Name of Insurance Company | Employer Name | Policy Number | |
| **B** Name of Policy Holder | | Social Security Number - - | What type of insurance? ☐ HEALTH ☐ PHARMACY ☐ DENTAL ☐ VISION |
| Name of Insurance Company | Employer Name | Policy Number | |
| **C** Name of Policy Holder | | Social Security Number - - | What type of insurance? ☐ HEALTH ☐ PHARMACY ☐ DENTAL ☐ VISION |
| Name of Insurance Company | Employer Name | Policy Number | |

## SECTION 4 – Health Care Information (Use additional sheets if needed.)

26. **PRIMARY CARE DOCTOR INFORMATION:**

| NAME OF PRIMARY CARE DOCTOR (First and Last) | DOCTOR'S ADDRESS (Number & Street, Suite, City, State, ZIP Code) | PHONE NUMBER |
|---|---|---|
| | | ( ) - |

27. List **ALL SPECIALTY** doctors who are treating the client:

| NAME OF SPECIALTY DOCTORS (First and Last) | DOCTOR'S ADDRESS (Number & Street, Suite, City, State, ZIP Code) | SPECIALTY AREA (If Known) | PHONE NUMBER |
|---|---|---|---|
| | | | ( ) - |
| | | | ( ) - |
| | | | ( ) - |
| | | | ( ) - |

28. List **ALL OTHER** health care providers (including hospitals, therapists, equipment and medical suppliers):

| NAME OF PROVIDER | PROVIDER'S ADDRESS (Number & Street, Suite, City, State, ZIP Code) | SERVICES PROVIDED | PHONE NUMBER |
|---|---|---|---|
| | | | ( ) - |
| | | | ( ) - |
| | | | ( ) - |
| | | | ( ) - |

29. **Check (X)** any Medical Equipment, Supplies, or Special Services the client uses now:

- ☐ Apnea Monitor
- ☐ Oxygen/Pulse Oximeter
- ☐ Ventilator/CPAP
- ☐ Tracheostomy Supplies/Suction Machine
- ☐ Nebulizer
- ☐ Glucometer
- ☐ Gastrostomy/Ostomy Supplies
- ☐ Hearing Aids
- ☐ Seating/Mobility Services
- ☐ Incontinence Supplies
- ☐ I.V. Supplies, TPN, Feeding Pump
- ☐ None of the above

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☐ OTHER: *(List below)*

30. What are the client's major health problems?

31. List the client's current medications:

## SECTION 5 – Coordination of Coverage for Family Members

32. List all others in client's household with CSHCS

| Client Name | CSHCS ID Number | Birth Date |
|---|---|---|
| Client Name | CSHCS ID Number | Birth Date |
| Client Name | CSHCS ID Number | Birth Date |

***NOTE:*** CSHCS coverage for the client usually begins the first day of the month this form is received by CSHCS. CSHCS may approve retroactive coverage up to six (6) months for past specialty medical services related to the CSHCS condition. CSHCS cannot guarantee the medical provider(s) will bill CSHCS for those past services. CSHCS cannot reimburse families for payments already made.
Check this box if this retroactive coverage is needed. ☐ Indicate the month that CSHCS needs to begin:

## SECTION 6 - Agreement, Certification and Signatures (required)

- By signing this application form, I am certifying that the information is accurate and complete to the best of my ability.
- I am certifying that I am the party responsible for the client's daily care.
- I understand that I will need to show proof of this information, including documentation if I am a court-appointed legal guardian or a foster parent.
- I agree that the Michigan Department of Health and Human Services and its agents or contractors may get and share information to determine the client's eligibility or need for specific services, to coordinate the provision of services, treatment, operations, payment, and for other administrative purposes related to the Children's Special Health Care Services (CSHCS) program.
- I understand that the information shared might relate to HIV, ARC, or AIDS if the client has those conditions.

| 33. Signatures | Date Signed | 34. The person(s) signing Box 33 is the: |
|---|---|---|
| | | ☐ **Parent of Minor Client** |
| Printed Name(s) | | ☐ **Court-Appointed Legal Guardian of Client**<br>☐ **Foster Parent of Client**<br>☐ **Adult Client** |

The Michigan Department of Health and Human Services does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

**AUTHORITY:** P.A. 368 of 1978, in cooperation with Title V of the Social Security Act **COMPLETION:** Is voluntary, but required if CSHCS program services are desired.

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