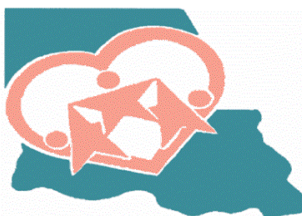


Mail or fax completed application to:

Empty box for mailing or faxing information.



Date received by CSHS office:

OPH ID:

Application for Children's Special Health Services

A note from the child's health care provider (doctor, nurse practitioner or audiologist) with the child/youth's suspected diagnosis or health condition should come with this form. Any of the following will be accepted—(1) have the health care provider complete Section 5 of this form; (2) attach a note from the health care provider with this information; (3) have the health provider mail or fax a note with this information to CSHS.

1. Where did you get this application?

- Doctor's office Hospital Parish Health Unit or CSHS Internet
 School Nurse Health Fair Neighborhood Place Other: _____

SECTION 1 – APPLICANT & HOUSEHOLD INFORMATION

2. Tell us about the child applying to CSHS.

Name (First, MI, Last): _____

Date of Birth (month/day/year): ____/____/____ Sex: Female Male

Social Security Number (SSN): _____ - _____ - _____ Write "NONE" if child does not have a SSN

Ethnicity: Hispanic Non-Hispanic Choose not to reply

Race: American Indian/Alaskan Native Asian Black/African American White
 Native Hawaiian/Pacific Islander More than one race Choose not to reply

Louisiana Resident? Yes No (please explain): _____

3. Tell us about the child's parent/guardian.

(If you are a youth over age 18 AND do not live with your parents, start at "Home address.")

Name (First, MI, Last): _____

Relationship to child: _____

Home address: _____ City: _____ State: _____ Zip: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Home # () _____ Work # () _____

Cell # () _____ E-mail: _____

What day, time and phone number is best to reach you Mon-Fri from 8 AM-4:30 PM?

Day: _____ Time: _____ Phone: Home Work Cell

4. Tell us about the child's other parent/guardian who does not live in the child's household.

(If no other parent/guardian OR if you are a youth over age 18 AND do not live with your parents, skip to question #5.)

Name (First, MI, Last): _____

Relationship to child: _____

Home # () _____ Work # () _____

Cell # () _____ E-mail: _____

5. How many people live in the household? _____

SECTION 2 – FINANCIAL & INSURANCE INFORMATION

6. Check all benefits the child currently receives that are listed below.

- Medicaid Medicare LaCHIP TriCare (Military Health Coverage) Private insurance No insurance

Note: If you check an item above, you must provide documentation at the first clinic visit.

You do not need to answer this question if the child has Medicaid/LaCHIP; skip to Question # 8

7. What is the total monthly income for all household members? This includes work and income from any of the following:

- | | | | |
|--------------------|------------------------------|------------------------------|-------|
| Social Security | Workman's Compensation | Alimony | Other |
| Child Support | Military family allotment | Retirement/Pension/Annuities | |
| Veteran's benefits | Interest/Dividends/Royalties | Refugee cash assistance | |

Total Income: \$ _____

Note: You must provide documentation for all income at the first clinic visit. In addition, you must also provide documentation of any of the following assets:

- | | | | |
|-------------------------|---------------------------|----------------------------|-----------------|
| Checking account | Stocks/bonds | Property (other than home) | Savings account |
| Certificates of deposit | Retirement accounts | Annuities/trusts | Share in estate |
| Lump sum settlement | Vehicles (if more than 2) | Promissory note | |

SECTION 3 – DISABILITY & HEALTH CARE INFORMATION

8. What is the child's diagnosis or disability? _____

9. Tell us about the doctors who have provided care in the last 2 years for the child's diagnosis or disability that was entered in Question 8.

Doctor's name	Doctor's address	Doctor's phone #

10. Has the child ever received any services from a parish public health unit in Louisiana?

No Yes → Enter the name of the parish(es): _____

SECTION 4 – CONTACT INFORMATION

11. List the names of friends, relatives or co-workers we may call if we cannot contact you.

Name	Relationship to you	Phone number(s)

- I am applying to CSHS for assistance for the child named in Question 2. The information I have given on this application is true and correct to the best of my knowledge.
- I agree to let CSHS get the information needed to verify the child's medical and financial situation. If I refuse to help with this process, it will mean that the child cannot receive services from CSHS until I do help.

Signature

Date

Parent/Legal guardian or Youth over 18 years of age
or Agency Representative/Title/Agency (if child/youth is in custody of this agency)

SECTION 5 – DIAGNOSIS CONFIRMATION TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER OR AUDIOLOGIST

Please verify the child's diagnosis or suspected health condition by completing this section or mailing/faxing a signed note to CSHS with this information.

Diagnosis/Health Condition: _____ Date: _____

Signature/Credentials (physician/nurse practitioner/audiologist): _____