Michigan Department of Community Health

Children's Special Health Care Services (CSHCS) Application

INSTRUCTIONS:

- Enter information in ALL sections.
- If you have any questions, please call **1-800-359-3722 or visit** **www.michigan.gov/cshcs**

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

PLEASE PRINT CLEARLY

- 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 COMMUNITY HEALTH
PO BOX 30734
LANSING MI 48909-8234

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. Work Phone ( ) –	15. Other Phone (where a message can be left) / Family Email Address ( ) –	
16a. Is this person adopted?	16b. Date of Adoption	16c. Previous Complete Name (if different)	

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

☐ **AFRICAN AMERICAN/BLACK** ☐ **AMERICAN INDIAN** ☐ **CAUCASIAN/WHITE** ☐ **HISPANIC/LATINO** ☐ **OTHER**

SECTION 2 – Responsible Relative/Court-Appointed Guardian Information:

18a. Name of Responsible Relative/Court-Appointed Guardian (Last, First, Middle)		18b. Name of Responsible Relative/Court-Appointed Guardian (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 responsible relative/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 - D** Claim #: ______________________

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

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	

COPY DISTRIBUTION: WHITE CSHCS/LHD; YELLOW FAMILY

SAMPLE

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 **OTHER** 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**

☐ **OTHER:** *(List below)*

COPY DISTRIBUTION: WHITE CSHCS/LHD
YELLOW FAMILY

SAMPLE

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

31. List the Client's current medications:

SECTION 5 - Involvement of Others

32. List all others in household with CSHCS:

Client Name	CSHCS ID Number	Birth Date
Client Name	CSHCS ID Number	Birth Date
Client Name	CSHCS ID Number	Birth Date
Client Name	CSHCS ID Number	Birth Date
Client Name	CSHCS ID Number	Birth Date

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 applicant's daily care.
- I understand that I may need to show proof of this information.
- I agree that the Department of Community Health 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, or for other administrative purposes related to the Children's Special Health Care Services (CSHCS) program, treatment, operations and payment.
- I understand that the information they share might relate to HIV, ARC, or AIDS if the Client has those conditions.

NOTE: CSHCS coverage for the client usually begins on the date this form is signed if received by CSHCS within 30 days of the signature date. If there are unpaid medical expenses for the client that are not the responsibility of another insurer (private insurance, Medicaid, Medicare, etc.), coverage may be requested for up to three months before the usual coverage begin date. CSHCS only pays for CSHCS covered specialty care to providers who participate with CSHCS.

33. SIGNATURES	DATE SIGNED	34. THE SIGNEE(S) IS A/AN:
		☐ **RESPONSIBLE RELATIVE of Client** ☐ **COURT-APPOINTED GUARDIAN of Client** ☐ **FOSTER PARENT of Client** ☐ **ADULT Client**
35. REQUESTED CSHCS COVERAGE BEGIN DATE:		

COPY DISTRIBUTION: WHITE CSHCS/LHD; YELLOW FAMILY

SAMPLE

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

The Department of Community Health is an equal opportunity employer, services, and programs provider.

SAMPLE

COPY DISTRIBUTION:	WHITE	CSHCS/LHD
	YELLOW	FAMILY