

# CSHCS SERVICE NEEDS SUMMARY RECORD

Michigan Department of Health and Human Services  
Children's Special Health Care Services

Child/Beneficiary ID Number	County Code
Child/Beneficiary Name	Date of Birth

**PROGRAM BASICS: Check all items that have been discussed with the family.**

<input type="checkbox"/> Application Complete, Eligibility Notice	<input type="checkbox"/> Prior Approval	<input type="checkbox"/> Trust Fund
<input type="checkbox"/> Providers Reviewed / Additional Needed	<input type="checkbox"/> W-9's	<input type="checkbox"/> Nursing, Respite
<input type="checkbox"/> Insurance / COBRA, Third Party	<input type="checkbox"/> Payment Agreement	<input type="checkbox"/> SHP's
<input type="checkbox"/> Transportation, Meals, Lodging	<input type="checkbox"/> Appeals	<input type="checkbox"/> MICHild
<input type="checkbox"/> Family Support Network	<input type="checkbox"/> Backdating	<input type="checkbox"/> Formula
<input type="checkbox"/> Medical Report / Releases	<input type="checkbox"/> Transitional Plan	<input type="checkbox"/> OTHERS (list below):
<input type="checkbox"/> Outstanding Bills / OOS / In-State Care		
<input type="checkbox"/> Incontinence Supplies		
<input type="checkbox"/> Written Materials given to Family		
<input type="checkbox"/> Family Support Subsidy / Adoption Subsidy / SSI		

**RESOURCES UTILIZED / REFERRALS MADE: ( KEY: U = Utilized, R = Referred)**

<b>Other Health Dept. Resources:</b>				
<input type="checkbox"/> WIC Program	<input type="checkbox"/> Family Planning	<input type="checkbox"/> Immunizations	<input type="checkbox"/> MSS	<input type="checkbox"/> ISS
<input type="checkbox"/> EPSDT	<input type="checkbox"/> Dental	<input type="checkbox"/> Healthy Kids (Medicaid)	<input type="checkbox"/> Other:	
<b>Community Mental Health:</b>				
<input type="checkbox"/> Family Support Serv.	<input type="checkbox"/> Children's Waiver	<input type="checkbox"/> Respite	<input type="checkbox"/> Other:	
<b>Family Independence Agency:</b>				
<input type="checkbox"/> Personal Care	<input type="checkbox"/> Food Stamps	<input type="checkbox"/> Other:		
<b>Educational Resources:</b>				
<input type="checkbox"/> Growth and Devel.	<input type="checkbox"/> Hearing and Vision	<input type="checkbox"/> Occup. Therapy (OT)	<input type="checkbox"/> Physical Therapy (PT)	
<input type="checkbox"/> Speech	<input type="checkbox"/> Early On	<input type="checkbox"/> Service Coordinator	<input type="checkbox"/> Other:	
<b>Other Resources / Services:</b>				
<input type="checkbox"/> Vocational Rehab.	<input type="checkbox"/> Transportation	<input type="checkbox"/> Support Groups	<input type="checkbox"/> Sup. Sec. Income (SSI)	
<input type="checkbox"/> Other:				

**ACTION / FOLLOW-UP:**

Local Health Department:	Family:	Care Coordination Authorization
		<input type="checkbox"/> Code <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 Duration
L.H.D. Contact Person Name (printed)	Date Prepared	L.H.D. Telephone Number (     )

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**AUTHORITY:** Title V of the Social Security Act

**COMPLETION:** Is voluntary, but required if CSHCS program services are requested.