Michigan Department of Community Health
Children's Special Health Care Services

CSHCS MEDICAL ELIGIBILITY REPORT

Instructions for Form MSA-4114

Purpose:

This form is used to determine if an individual is medically eligible for the Children's Special Health Care Services (CSHCS) program. The condition must require the services of a medical and \ or surgical sub-specialist at least annually, as opposed to being managed exclusively by a primary care physician. A current list of covered diagnoses is maintained on the MDCH website at www.michigan.gov/mdch. In addition, some diagnoses must meet severity or chronicity criteria (e.g. asthma).

This form should be completed for the following persons:

- Anyone, **UNDER 21** years of age with a potentially eligible condition. Psychiatric, emotional and behavioral disorders, attention deficit disorder, developmental delay, mental retardation, autism, or other mental health diagnoses are **not** conditions covered by the CSHCS program.
- Anyone, regardless of age, with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia.

Completion Instructions:

- Read this instruction page thoroughly. Then separate attached forms.
- Please **TYPE** or **PRINT** clearly in INK.
- The **Physician's Signature** (or the Attending Physician if a Hospital) and the **Date Signed** are **REQUIRED**.
- If desired, make a photocopy for your records.
- **FAX (517 335-9491) or Mail** the completed form to:
  CSHCS DIVISION
  MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
  PO BOX 30734
  LANSING MI 48909-8234

Other Information:

- If this request is approved, the client is medically eligible for the CSHCS program.
- For actual program coverage, the client or the client's family MUST APPLY to join the CSHCS program by completing form **MSA-0737**, APPLICATION FOR CHILDREN'S SPECIAL HEALTH CARE SERVICES.
- If the family does NOT receive an application after notification of approval, please call **1-800-359-3722**.

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 (TTY 1-866-501-5656).
Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono **1-800-642-3195** (TTY 1-866-501-5656)
Arabic: 1-800-642-3195 (TTY 1-866-501-5656)

إذا كان لديكم أيّ سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ١-٨٠٠-٦٤٢-٣١٩٥

AUTHORITY: Title V of the Social Security Act
COMPLETION: Completion is Voluntary, but is required if coverage under the Children's Special Healthcare Services Program is desired.

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

Michigan Department of Community Health
Children's Special Health Care Services (CSHCS)

MEDICAL ELIGIBILITY REPORT

CLIENT INFORMATION:

CLIENT'S Name (Last, First, Middle)		Date of Birth	Sex ☐ **MALE** ☐ **FEMALE**
CLIENT'S Address (Number, Apt. No., Lot No.)		Social Security Number	HOME Phone Number ( ) -
City	State / ZIP Code	County	WORK Phone Number ( ) -
Does Client have other Health Insurance? ☐ **NO** ☐ **YES** (Co. Name):		Is Client enrolled in Medicaid? ☐ **NO** ☐ **YES** (Medicaid ID No.):	

Racial/ Ethnic Heritage (Check all that apply) (You are not required to complete this information.)
☐ Alaska Native ☐ American Indian ☐ Arabic ☐ Asian ☐ African American/Black ☐ Hispanic or Latino
☐ Caucasian/White ☐ Multi-racial/Ethnic ☐ Native Hawaiian/Other Pacific Islander ☐ Other:

PARENT(S) OR LEGALLY RESPONSIBLE PARTY INFORMATION: (Check appropriate box and complete information.)

☐ FATHER or ☐ LEGALLY RESPONSIBLE PARTY Name		☐ MOTHER or ☐ LEGALLY RESPONSIBLE PARTY Name	
Street Address (if different from client's)		Street Address (if different from client's)	
City	State / ZIP Code	City	State / ZIP Code
Social Security Number	Relationship to Client	Social Security Number	Relationship to Client
HOME Phone Number ( ) -	WORK Phone Number ( ) -	HOME Phone Number ( ) -	WORK Phone Number ( ) -

CLIENT MEDICAL NEEDS INFORMATION:

DIAGNOSIS: *(If Newborn, give birth weight)* **Primary:**	**Other:**
SEVERITY/COMPLICATIONS/CHRONICITY:	
HISTORY:	
TREATMENT PLAN: (Include names of specialists involved, and any special needs such as surgery, medications, supplies, therapies, equipment)	
What care will this Client need? ☐ **HOSPITAL** ☐ **HOME CARE** ☐ **Other** (explain) -	Requested Coverage Begin Date:
PROGNOSIS:	

HOSPITAL Name		Hospital Case Record Number
Hospital Contact Person (Name and Title)		Hospital Phone Number ( ) -
PHYSICIAN'S Name (Print)		Physician's Phone Number ( ) -
Physician's Address (Number and Street)		Physician's Signature ***(REQUIRED)*** / Date Signed
City	State / ZIP Code	

For CSHCS Use Only

☐ **APPROVED** - **The client must now complete enrollment process for coverage.** This client is **medically eligible** for the CSHCS Program for diagnosis code(s):

_____

☐ **DISAPPROVED** - This client is **NOT** medically eligible for the CSHCS Program. Reason:

_____

☐ Eligible for Diagnostic Evaluation at:_____

_____

☐ Pending / Other:

CSHCS Signature Date

MSA-4114 (11-06) Previous versions may be used.