Children with Special Needs Fund

…enhancing the lives of children with special needs in Michigan since 1944

Michigan Department of Health and Human Services
Children with Special Needs Fund
PO Box 30734 Lansing, MI 48909
Phone: (517) 241-7420 Fax: (517) 335-8055
www.michigan.gov/csnfund

CSN Fund Application Guidelines

What does the CSN Fund do? The Children with Special Needs Fund helps families with children with special health care needs who need assistance to obtain special equipment. The CSN Fund is privately funded, the payer of last resort, and it cannot replace state or federal funding/programs. It is administered through the Michigan Department of Health and Human Services (MDHHS), Children's Special Health Care Services (CSHCS) Division.

Who is eligible to apply to the CSN Fund? Families with a child under the age of 21, who is enrolled or medically eligible to enroll in the CSHCS Program may apply for assistance for an item related to a CSHCS diagnosis. To find out if your child is eligible, contact the CSHCS office at your Local Health Department**.** Please note: Children enrolled in Adoption Medical Subsidy, Children's Waiver, Habilitation Supports Waiver, Community Mental Health, or have a Trust/Insurance Settlement must apply to these sources FIRST before contacting the CSN Fund. The CSN Fund is privately funded, is the payer of last resort, and it cannot replace state or federal funding/programs. It is intended to assist families without other resources.

What are the income eligibility criteria? For families earning less than $400,000 per year there is no income limit. Those earning more than $400,000 must include an explanation of hardship describing their need for assistance. If a child is not currently enrolled in CSHCS, the financial assessment form (DCH-1273) must be submitted with the application.

Does the CSN Fund reimburse for equipment or services? No, the CSN Fund will not reimburse a family, business, or funding source for equipment already provided or purchased.

What if I need help with my application? Your Local Health Department can help! CSHCS staff at the Local Health Department can help with the application process, locate nearby vendors, and find local agencies who may be able to help. Local CSHCS staff may not gather the estimates for equipment on your behalf. Call your local health department or the CSHCS Family Phone Line at 1-800-359-3722.

Are there items NOT covered by the CSN Fund? Yes, certain items are not covered including:

- Personal care items, baby/video monitors, equipment, and appliances routinely found in a home
- Improvements or repairs to a vehicle or home, including modifications to the home (i.e., bathroom, widening doors)
- Vehicle purchase or lease
- Generators, humidifiers, air purifiers, heating/furnace installation
- Central air conditioning, ceiling/stair lift, or platform lift in a rental property

Do I have everything required to request an item?

- ○ CSN Fund Application (Form DCH-1239). Use a separate application for each item being requested.
- ○ Financial Assessment Form DCH- 1273 (only if your child **IS NOT** enrolled in CSHCS).
- ○ Letter from you explaining the need and reason for the request. If income is more than $400,000, include explanation of financial hardship.
- ○ Letter of medical necessity from the child's specialist (*not the pediatrician*) explaining the need for the requested item. Tricycles or adaptive recreational equipment requests must include an assessment from PT/OT.
- ○ Documentation of Assistance form (DCH-2423).
- ○ Bids/quotes for the item (see table on page 2). Vendors should be willing to register & bill the State of Michigan.
- ○ Rifton (or AMTRYKE) order form completed by OT/PT (if applying for Rifton or AMTRYKE).
- ○ Signed landlord agreement form (DCH-2424) for wheelchair ramp or electrical upgrade on a rental property.

PLEASE NOTE

- *Families with more than one eligible child may be given special consideration to determine the amount of funding.*
- *The amount of funding is based on the lowest quote. If the family selects a vendor higher than the lowest quote, the family is responsible for the difference. Quotes must be from different vendors.*
- *Applications cannot be processed if they are not fully completed or if the required documentation is not attached.*
- *Please encrypt emailed applications. If you do not encrypt your email, there is a risk an unauthorized end user could receive it.*
- *If there is a problem with approved equipment, contact the CSNF immediately for assistance. Equipment may not be returned or exchanged without the written approval of the CSNF.*

Type of Equipment and Amount of Assistance Provided

Equipment	Limit	Exclusions/Restrictions	Number of Quotes Needed	Maximum Assistance
Adaptive Recreational Equipment	No duplicate requests within 5 years	Up to 3 adaptive toys (and 3 switches if needed) in a 2-year period (not to exceed $600 total). No limit on number of other items, up to $3,000 (total).	1 quote for adaptive toys & switches; 3 quotes from different vendors for all other items	$600 adaptive toys or switches $3,000 all others
Air Conditioners	One (1) per child	Child must have a documented medical diagnosis of severe and persistent asthma, respiratory distress, or other medical condition worsened by heat and humidity, as determined by the CSHCS medical consultant(s).	None (ordered directly from vendor)	$550
Ceiling/Stair Lifts	One (1) per family	Not allowed for rental units. Ceiling & stair lifts are based on availability of special grant funds. Must include installation diagrams.	3 quotes from different vendors with installation diagrams	Determined by Advisory Committee
Central Air Conditioning	One (1) per family	Not allowed for rental units. Child must have a documented medical diagnosis of severe and persistent asthma, respiratory distress, or other medical condition worsened by heat and humidity, as determined by the CSHCS medical consultant.	1 quote	$1,000
Electrical Upgrades	One (1) per family	For safe operation and function of medical equipment in the home. A signed landlord agreement (Form DCH-2424) must be included if the home is a rental property.	2 quotes from different vendors	$1,000
Platform Lift	One (1) per family	Only when ADA-compliant ramp cannot be installed. Not allowed for rental units. Must include property photos and vendor justification to demonstrate a ramp cannot be installed ADA-compliant.	3 quotes from different vendors with installation diagrams	$10,000
Tie Downs	No limit	Tie downs may be replaced as needed.	3 quotes from different vendors	$1,000
Tricycle	Every 2-5 years	A PT/OT assessment for bike/trike requests must be included with the application. For Rifton trikes, a Rifton Order Form must be completed by PT/OT. For AMTRYKEs, visit www.ambucs.org/join/chapter-directory/ to find the chapter closest to you.	No quote for Rifton 1 quote for AMTRKE 3 quotes from different vendors for all other types	$2,800
Vehicle Accessibility Devices	Up to two (2) per family - Second request > 5 years after first request	Funding is only allowed for the cost of the accessibility device(s) (i.e. van lift, ramp, tie downs, etc.), not the purchase of the vehicle itself, including Amish buggies. Buggy requests must also include a quote for a non-adapted buggy for comparison.	3 quotes from different vendors with vehicle and accessibility device(s) itemized	$12,000
Wheelchair Ramps	One (1) per family	Ramps must meet Americans with Disabilities Act (ADA) requirements and any other federal, state, and/or local ordinances and requirements that may apply. A signed landlord agreement (Form DCH-2424) must be included if the home is a rental property.	3 quotes from different vendors with installation diagrams	$5,500

Decisions

While it is our mission to help as many children as possible, not all requests can be granted. **PLEASE ALLOW FOUR TO SIX WEEKS FOR ROUTINE DECISIONS TO BE MADE.** *Urgent requests should be explained in your letter or call (517) 241-7420.* Some requests may be reviewed by the CSN Fund Advisory Committee and require additional time for decisions to be made. Once a decision is made a letter will be mailed to you. Funding is from private donations. No state or federal funds are used; therefore, all decisions are final, and there is no appeal process.

Applications are available to download at www.michigan.gov/csnfund, at your local health department, or by contacting the CSN Fund office. A survey will be emailed to the family after service/equipment has been paid by the CSN Fund.

Contact CSNF
Email: csnfund@michigan.gov
Phone: (517) 241-7420
Family Phone Line: (800) 359-3722

Submit Applications
Children with Special Needs Fund
PO Box 30734, Lansing, MI 48909
Fax: (517) 335-8055 **OR** Email:* csnfund@michigan.gov

Please encrypt emailed applications. If you do not encrypt your email, there is a risk an unauthorized end user could receive it.

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Application

1. Check the item you are requesting (If requesting more than one item, use a separate application for each item):

- ☐ *Adaptive Recreational Equipment*
- ☐ *Air Conditioner - Portable*
- ☐ *Air Conditioner - Window Unit*
- ☐ *Ceiling Lift or Stair Lift*
- ☐ *Central Air Conditioning*
- ☐ *Electrical Upgrade*
- ☐ *Platform Lift (in place of ramp)*
- ☐ *Tricycle*
- ☐ *Tie Downs*
- ☐ *Vehicle Accessibility Device*
- ☐ *Wheelchair Ramp*
- ☐ *Other (please describe):* _____

2. Please read the Application Guidelines before you complete this application.

Applicant Information	Your relationship to the child: ☐ Custodial Parent ☐ Legal Guardian
Child's Last Name / Child's First Name	Do you: ☐ Rent your home or ☐ Own your home
Child's CSHCS ID Number (10-digits) / Child's Date of Birth (MM/DD/YYYY)	Did your Local Health Department help with this application? ☐ Yes ☐ No
Parent/Guardian Last Name / Parent/Guardian First Name	What is your preferred method of contact? ☐ Home Phone ☐ Cell Phone ☐ Email
Address	Is interpretation or translation needed? *If Yes, please explain:* ☐ Yes ☐ No
City / Zip / County	
Home Phone / Cell Phone / Email	

3. If applying for an Air Conditioner, please provide the room square footage: _____

4. Please check any program from which your child currently receives services:

- ☐ Adoption Medical Subsidy*
- ☐ Children's Waiver*
- ☐ Community Mental Health *
- ☐ Family Incentive Grant (Foster Care)*
- ☐ Habilitation Supports Waiver*
- ☐ Trust/Insurance Settlement*

**You must apply to this agency/program first. If your request is denied, include a copy of the denial letter with this application. The CSN Fund is a private fund and payer of last resort; it cannot be used to replace state or federal programs.*

5. Preferred Vendor Name _____ Vendor Name

Application Checklist *(Applications missing any required documents cannot be processed until all documents are received)*

- ☐ Completed Application Form DCH-1239 *(submit a separate application for each item you are requesting)*
- ☐ Completed Financial Assessment Form DCH- 1273 (ONLY if *child is not enrolled in the CSHCS program)*
- ☐ Completed Documentation of Assistance Form DCH-2423
- ☐ A letter from you explaining the need and reason for the request; if you earn more than $400,000, please explain the hardship(s) you are facing that prompted this request for assistance
- ☐ A letter of medical necessity from the child's specialty physician (*not their pediatrician*)
- ☐ Bids/quotes required for the item you are requesting *(See page 2 of Application Guidelines)*
- ☐ Assessment from Physical/Occupational Therapist for adaptive bike/tricycle requests
- ☐ Installation diagrams for ceiling lift, stair lift, platform lift, and wheelchair ramp requests
- ☐ Completed Rifton Order Form DCH-1342 (*for Rifton Tricycle Requests only)*
- ☐ Signed Landlord Agreement Form DCH-2424 (*for a wheelchair ramp or electrical upgrade on rental property)*

▶Please encrypt emailed applications. If you do not encrypt your email, there is a risk an unauthorized end user could receive it◀

6. *Signature(s):* *I certify that the information on this form is true and complete to the best of my knowledge. I understand that this application may be reviewed by the CSN Fund Advisory Committee.*

Signature of requester (if over 18) _____ Date _____ Signature of parent/guardian _____ Date _____

Clear Form

Authority: Public Act 368, P.A. of 1978
Completion: Is voluntary, but the information is necessary to receive funding from CSN Funds.
DCH-1239 (01/2026 Previous editions are obsolete.

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Financial Assessment

PLEASE NOTE: ONLY complete this form if the child is NOT enrolled in Children's Special Health Care Services (CSHCS)

Applicant's (CHILD) Information _____
Last Name First Name

Parent or Guardian Information _____
Last Name First Name

Does the child live in a foster home or private placement agency? ☐ Yes ☐ No

Income information

Enter the total number of claimed exemptions from your most recent federal tax form ..... _____

Enter the responsible party's adjusted gross income from the most recent **Federal Tax Form** (Line 11 of the Federal 1040)..... $ _____

The person signing is the*: (check one)*

☐ Custodial Parent ☐ Non-Custodial Parent ☐ Legal Guardian ☐ Foster Parent of Child
☐ Adult Client *(between 18 to 21 years old)*

Income Verification

- ❖ I certify under the penalty of perjury that the information on this form is true, complete, and accurate to the best of my knowledge.
- ❖ I authorize the State of Michigan to verify any information on this form.

_____
Signature of Adult Client or Legally Responsible Party Date Signed

_____
Print Name Signed Above

Authority: Public Act 368, P.A. of 1978
Completion: Is voluntary, but the information is necessary to receive funding from CSN Funds.
DCH-1273 (01/2026) Previous editions are obsolete.

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Documentation of Assistance

As a payer of last resort, the CSN Fund requires applicants to contact at least two other charitable organizations (i.e., service clubs, faith-based, charity, or community-based organizations, etc.) for assistance with the requested item. Denials from Medicaid or insurance are not needed nor qualify as charitable organizations. Please complete this form and submit it with your application and include any letters or e-mails received from these organizations.

Please note: *Families are expected to contact other organizations for assistance. If you are having difficulty doing this, assistance may be provided by local health department staff, case manager, etc. A list of charitable resources can be found at www.michigan.gov/csnfund/resources.*

1. Name of organization you contacted: _____

a. Date of contact: _____

b. Name of representative you contacted: _____

c. Phone number of organization: _____

d. Will they help with funding the request? ☐ YES ☐ NO

e. If yes, how much will they contribute towards the item/equipment? $ _____

2. Name of organization you contacted: _____

a. Date of contact: _____

b. Name of representative you contacted: _____

c. Phone number of organization: _____

d. Will they help with funding the request? ☐ YES ☐ NO

e. If yes, how much can they contribute towards the item/equipment? $ _____

I certify that the information on these forms is true, complete, and accurate to the best of my knowledge.

_____

_____

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Landlord Agreement

This form should be completed by the **landlord/owner** of the rental property where the requestor resides.

1. Name of landowner/landlord: _____

2. Address of landowner/landlord:

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

3. Address of rental property where modifications will be made:

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

4. Name of tenant residing at the rental property above: _____

I, the landlord/landowner, give permission to the Children with Special Needs Fund (CSN Fund) to fund the item indicated below for the rental property at the rental property address listed above.

- ☐ Wheelchair Ramp
- ☐ Electrical Upgrade

I certify that the agreement between the landlord and the tenant allows the tenant to make the modification above to the property and if it does not, I agree to amend the lease with the tenant accordingly.

Landlord Signature _____ Date: _____

Tenant Signature: _____ Date: _____

The Children with Special Needs Fund (CSN Fund) is not liable for damages or charges incurred from damages to the property listed above during or after the modification, or restoration of the property to its original condition, in the event the tenant relocates from the property.

Authority: Public Act 368, P.A. of 1978
Completion: Is voluntary, but the information is necessary to receive funding from CSN Funds.
DCH-2424 (01/2026) Previous editions are obsolete.

Michigan Department of Health and Human Services (MDHHS)

Please note if needed, free language assistance services are available.
Call 800-359-3722 (TTY 711).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-359-3722 (TTY 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-359-3722 (رقم هاتف الصم والبكم: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-359-3722 （TTY 711）
Syriac (Assyrian)	ܙܘܗܪܐ: [illegible] 800-359-3722 (TTY 711)
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-359-3722 (TTY 711).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 800-359-3722 (TTY 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-359-3722 (TTY 711)번으로 전화해 주십시오.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ 800-359-3722 (TTY ১ 711).
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-359-3722 (TTY 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 800-359-3722 (TTY 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-359-3722 (TTY 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-359-3722（TTY 711）まで、お電話にてご連絡ください
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-359-3722 (телетайп 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 800-359-3722 (TTY Telefon za osobe sa oštećenim govorom ili sluhom 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-359-3722 (TTY 711).

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Section 1557 Coordinator. The contact information is found below.

If you believe that MDHHS has not provided the above services, or discriminated in another way, you can file a grievance with the Section 1557 Coordinator. You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
Compliance Office, Suite 411
PO Box 30037
Lansing, MI 48909

517-284-1018 (Main), (TTY number—if covered entity has one), 517-335-6146 (Fax), MDHHS-Section-1557@michigan.gov (Email).

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD) Complaint forms are available at https://bit.ly/2IKsHMS.	If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by: Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.
MDHHS-1557 CSHCS (Rev. 12-22)