

CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS) APPLICATION

Michigan Department of Health and Human Services

INSTRUCTIONS:

- Enter information in ALL sections.
- If you have any questions, please contact a CSHCS representative at your local health department, call 1-800-359-3722, or visit www.michigan.gov/cshcs.

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

- 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 HEALTH AND HUMAN SERVICES
PO BOX 30734
LANSING MI 48909-8234 **Fax: 517-335-9491**

PLEASE PRINT CLEARLY

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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
City	State	ZIP Code	7. <input type="checkbox"/> Check if Child has Died		8. Date of Death	
9. County Client Lives in		10. U.S. Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO	11. Michigan Resident? <input type="checkbox"/> YES <input type="checkbox"/> NO		12. Migrant Farm Worker? <input type="checkbox"/> YES <input type="checkbox"/> NO	
13. Home Phone - -		14. Cell Phone - -		15. Family Email Address		
16a. Is this person adopted?		16b. Date of Adoption		16c. Previous Complete Name (if different)		
17a. IF Hispanic / Latino, ethnicity – Check One (You are not required to complete this information.) <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other						
17b. Racial / Ethnic Heritage - Check One (You are not required to complete this information.) <input type="checkbox"/> White <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Guamanian / Chamorro <input type="checkbox"/> Black / African American <input type="checkbox"/> Asian Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Other Asian <input type="checkbox"/> Samoan <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander						

SECTION 2 – Parent, Court-Appointed Legal Guardian, or Foster Parent Information

18a. Name (Last, First, Middle)			18b. Name (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 - -		21b. Social Security Number - -	
22. Is at least one parent/court-appointed guardian a US Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO			Michigan Resident? <input type="checkbox"/> YES <input type="checkbox"/> NO Migrant Farm Worker? <input type="checkbox"/> YES <input type="checkbox"/> NO		

SECTION 3 – Health Coverage and Insurance Information

23. Is this client receiving any of the following programs? (<i>check all that apply</i>)		24. Are the major health problems related to an accident or birth injury? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> MEDICAID ID#: _____	<input type="checkbox"/> MEDICARE - A Claim #: _____	
<input type="checkbox"/> MICHild	<input type="checkbox"/> MEDICARE - B Claim #: _____	
	<input type="checkbox"/> MEDICARE - C Claim #: _____	
	<input type="checkbox"/> MEDICARE - D Claim #: _____	

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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? <input type="checkbox"/> HEALTH <input type="checkbox"/> PHARMACY <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION
	Name of Insurance Company	Employer Name	Policy Number	
B	Name of Policy Holder		Social Security Number - -	What type of insurance? <input type="checkbox"/> HEALTH <input type="checkbox"/> PHARMACY <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION
	Name of Insurance Company	Employer Name	Policy Number	
C	Name of Policy Holder		Social Security Number - -	What type of insurance? <input checked="" type="checkbox"/> HEALTH <input type="checkbox"/> PHARMACY <input checked="" type="checkbox"/> DENTAL <input type="checkbox"/> 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 SPECIALTY 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:

- | | |
|--|---|
| <input type="checkbox"/> Apnea Monitor | <input type="checkbox"/> Gastrostomy/Ostomy Supplies |
| <input type="checkbox"/> Oxygen/Pulse Oximeter | <input type="checkbox"/> Hearing Aids |
| <input type="checkbox"/> Ventilator/CPAP | <input type="checkbox"/> Seating/Mobility Services |
| <input type="checkbox"/> Tracheostomy Supplies/Suction Machine | <input type="checkbox"/> Incontinence Supplies |
| <input type="checkbox"/> Nebulizer | <input type="checkbox"/> I.V. Supplies, TPN, Feeding Pump |
| <input type="checkbox"/> Glucometer | <input type="checkbox"/> None of the above |

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☐ OTHER: (List below)

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

31. List the client's current medications:

SECTION 5 – Coordination of Coverage for Family Members

32. List all others in client's household with CSHCS

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

NOTE:

CSHCS coverage for the client usually begins the first day of the month this form is received by CSHCS. CSHCS may approve retroactive coverage up to six (6) months for past specialty medical services related to the CSHCS condition. CSHCS cannot guarantee the medical provider(s) will bill CSHCS for those past services. CSHCS cannot reimburse families for payments already made.

Check this box if this retroactive coverage is needed. ☐ Indicate the month that CSHCS needs to begin:

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 client's daily care.
- I understand that I will need to show proof of this information, including documentation if I am a court-appointed legal guardian or a foster parent.
- I agree that the Michigan Department of Health and Human Services 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, treatment, operations, payment, and for other administrative purposes related to the Children's Special Health Care Services (CSHCS) program.
- I understand that the information shared might relate to HIV, ARC, or AIDS if the client has those conditions.

33. Signatures	Date Signed	34. The person(s) signing Box 33 is the: <input type="checkbox"/> Parent of Minor Client <input type="checkbox"/> Court-Appointed Legal Guardian of Client <input type="checkbox"/> Foster Parent of Client <input type="checkbox"/> Adult Client
Printed Name(s)		

The Michigan Department of Health and Human Services does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

AUTHORITY: P.A. 368 of 1978, in cooperation with Title V of the Social Security Act

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

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