MDHHS
Michigan Department of Health & Human Services
Children's Special Health Care Services

Family Center for CYSHCN
Local Health Department Referral Form

Please check all resources/support the family is requesting and fax or email* to the Family Center.

- ☐ Bereavement resources
- ☐ Information on Conference Scholarships
- ☐ Information on Camp Scholarships
- ☐ Family Engagement & Leadership Opportunities
- ☐ Peer Support Opportunities
- ☐ Referral to community-based organizations
- ☐ Sibling support/Sibshop training
- ☐ Training and webinars
- ☐ Transition to Adult Healthcare
- ☐ Other:

Please print	
Parent/Caregiver/Legal Guardian's Name	Phone Number
Email Address	County of Residence
Preferred Method of Contact ☐ Email ☐ Phone	Primary Language
Child's Name	Child's Primary Diagnosis
Child's CSHCS ID# or Medicaid #	
Parent/Caregiver/Legal Guardian's Signature	Date
CSHCS LHD Information (please print)	
Name of Local Health Department	Phone Number (include ext if needed)
Name of Referring Individual	Date
Check here if parent gave verbal permission to release their information ☐	

Instructions to submit to Family Center

- Fax to 517-241-8970 or
- Email to cshcsfc@michigan.gov (*please remember to encrypt the email)