CHILDREN'S SPECIAL HEALTH AND DENTAL SERVICES APPLICATION

Name: _____ Date of Birth: _____
Last First MI

Check Program(s) Client is Applying For: ☐ CSH ☐ MHR ☐ NBIC ☐ Dental ☐ Crippling Malocclusion

Tier Level: 1 2 3 Referral Date: _____
(Circle)

Eligibility Date Requested: _____

Who is the client's Primary Care Provider? (Medical Home) _____

In the Request Service (**RS**) column below, please write number '1' for Diagnostic Evaluation or Referral or '2' for Established diagnosis next to the current or potential provider(s) where the client may be referred. Choose **Provider Type Code** from the list below. For the Medical Records Field (**MR**) choose 1 (Not applicable), 2 (Enclosed), 3 (Requested but not received), or 4 (CSH to request and send copy to PHN).

RS	***Provider's Full Name*, Address and Phone Number**	***Provider Type Code***	***Diagnosis/ Symptoms***	***Date of Last Appointment***	***Date of Next Appointment***	***MR***

If needed, list Relevant Providers who may be able to provide pertinent history on the client's condition:

Provider's Full Name , Address and Phone Number	***Provider Type Code***	***Date Last Seen***	***MR***

Provider Type Codes:

1. Audiologist
2. Cardiologist
3. Dentist
4. Endocrinologist
5. Speech Therapist
6. Gastroenterology
7. Geneticist
8. Neurologist
9. Ophthalmologist
10. Orthodontist
11. Orthopaedist
12. Pediatrician
13. Pulmonologist
14. Urologist
15. ENT
16. Physical Therapist
17. Surgeon - What Type? _____
18. Other:_____

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Are there siblings on CSH? *Yes* ☐ *No* ☐ *If yes, please print their names(s) and Case # ('s)*

_____

Has client applied for CSH within the past two years? Yes ☐ *No* ☐

Other Programs:
Is the client on SSI? Yes ☐ *No* ☐ *SSI#*_____
Is the client on The Children's Medicaid Waiver? Yes ☐ *No* ☐

If yes, who is the Individual's Service Coordinator (ISC)? _____

Special Request(s):

Specialty Clinic(s)

*Location of Clinic*_____
Location of Clinic _____

Travel Assistance *Yes* ☐ *No* ☐

Other Special Requests

_____

_____

_____

_____

_____

_____ _____ _____
Care Coordinator's Signature *County* *Date*