CSHCS ENROLLMENT PACKET
State Form TEST (27757) 04/08

Indiana State Department of Health
Maternal & Children's Special Health Care Services

THIS PACKAGE CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC.3.2-10 and 410 IAC 3.1-2-18

INSTRUCTION: If you have questions, please call 1-800-475-1355 Eligibility Option and ask for Training Coordinator.

THIS APPLICATION WILL NEED TO DOWNLOADED, COMPLETED AND MAILED TO THE ISDH/CSHCS PROGRAM:

ISDH/CSHCS
Section 7B
2 N Meridian
Indianapolis IN 46204

Children's Special Health Care Services Enrollment Packet consists of 17 pages. Please **print** all information except where signatures are required. The program serves Indiana residents age 0-21. Applicants with Cystic Fibrosis can apply to this program **at any age**, but must be financially eligible.

Remember the **Application Date** must be on all pages where a date is required. Exception – page 13 should be current date because this form is only good for 60 days. The completed enrollment packet must be submitted to CSHCS within 30 days of the application date.

Page 3: Enrollment Form Checklist. This checklist will help to ensure that you are submitting all necessary documents. **If you are sending this application for diagnostics, the family must be financially eligible for CSHCS.** If family refuses to cooperate or does not return requested documentation, submit application for denial and check appropriate reason.

Page 4: Applicant's and parent/guardian information. The **Application Date** is the date you are completing the form. Mark the form New Enrollment. The CSHCS Key # and Effective Date will be completed by ISDH staff. The remainder of the form is self-explanatory. There are some exceptions:

a) only a parent (regardless of age) or legal guardian can sign this application, so if the applicant is a Ward of the County/State, the caseworker's information goes on the 1st line for parent/guardian and the foster parent's information can go on the 2nd line;

b) a surrogate parent (First Steps) or a Foster Parent can not sign this application.

We need to know the medical condition for applying to CSHCS. This can be exactly what the doctor has told you and/or the parent.

Page 5: Household Members and Income Information. List all persons living under roof as an Economic Unit regardless if related or not (i.e. mom, child & mom's boyfriend). We would count boyfriend's income. A pregnant woman is considered 1 person. We do not count the child until it is born. There are no special codes to use, just put m=mom, d=dad, a=applicant, o= other, b=brother, etc. There are some exceptions, so if you have an unusual situation, call. They are too numerous to list. Complete across the table and for Insurance, put Y or N.

The CSHCS program counts **ALL** income for the household and we use GROSS amounts. The CSHCS program requires that Income documentation be submitted with the application and **preferred documentation** is latest Federal 1040 that was filed. If they state they have no income, ask, document and request written and signed statements on how they pay rent, buy food, pay utilities, etc. The Intake person will sign & date the bottom of the income page.

Page 6: Medical Insurance Information form – complete boxes 1 & 2 always. Boxes 3-7 should be completed only if there is private insurance.

Page 7: Social History Interview – Complete as fully as possible.

Page 8: Medicines and Medical Equipment – Complete as fully as possible**.**

Page 9: Application for Enrollment form – read, sign, and date. The Intake person signs as verification of signature of Applicant, Parent or Guardian.

Page 10: Authorization for the Collection of Information – read, sign, and date. The Intake person signs as verification of signature of Applicant, Parent or Guardian.

Page 11: Authorization for the Release of Protected Health Information – This form allows CSHCS to exchange information with the Intake person and or site.

Page 13: Authorization to Release and Share Medical Information – REMEMBER: put **current date** on this form. Complete one for each provider that the parent/guardian/applicant says can verify diagnosis. *If the parent/guardian/applicant has medical that can be submitted with the application, there is no need to send this form anywhere.* ***However, the form must be completed and submitted with the application***.

This form may be copied to accommodate additional providers. When sending to more than one provider, remember to copy the back of the form. **A copy or copies of the completed form must be submitted with the application.**

Page 15: Physician's Health Summary Form. This page is to be mailed or given, along with the Authorization to Release & Share Medical Information form, to the provider or providers who the parent/guardian/applicant says can verify diagnosis. If the parent/guardian/applicant has medical it can be submitted with the application and there would be no need to mail the form; however, it should be sent with the application.

Page 16: Hoosier Healthwise/Medicaid*: If the applicant is not on Hoosier Healthwise /Medicaid, this form needs to be completed and mailed to the Applicant's County Division of Family Resources. A copy of this form (front & back) should be submitted with the CSHCS application.*

If applicant is age 19 or older, they must apply for the most appropriate Medicaid program and supply proof of submitted application.

NOTE: If you have any questions, please call 1-800-475-1355, Eligibility Option and ask to speak with Training Coordinator. The direct number is 317-233-5571.

ENROLLMENT CHECKLIST
State Form TEST (27757) 04/08

Applicant's Name _____ D.O.B. _____

_____**APPLICATION IS FOR DIAGNOSTICS (applicant is financially eligible for CSHCS)**

_____Income page signed, income documentation attached

_____Hoosier HealthWise/Medicaid: Submit documentation that applicant either has or has applied. **(THIS IS A MANDATORY REQUIREMENT OF THE CSHCS PROGRAM).**

_____Medical Insurance Information page completed (if applicable), signed, dated, and a copy of either HHW card or insurance card (front & back) attached, if possible.

_____Authorization for the Collection of Information form signed and dated

_____Authorization for the Release of Protected Health Information form signed and dated

_____Application for Enrollment with CSHCS page signed and dated

_____Copy of Authorization to Release & Share Medical information completed, signed and dated attached **(original to be sent to medical provider to verify diagnosis).**Separate form for each medical provider to be contacted.

_____**APPLICATION IS RECOMMENDED FOR DENIAL** ***(if the application has been signed by the parent/legal guardian/applicant it must be submitted)***

___ Voluntary Withdrawal of Application
(requires written confirmation from parent/guardian/applicant)

___ Applicant is Over Age 21

___ Failure to Apply for Medicaid/HHW

___ Failure to Complete Application Process

___ Failure to Disclose Income

___ Family is Financially Ineligible

___ Other: _____

Please mail application and all documentation within 30 days of Application date to:

Children's Special Health Care Services (CSHCS)
ATTN: Eligibility Section
Indiana State Department of Health
2 North Meridian St., Section 7-B
Indianapolis, IN 46204

CSHCS Enrollment Application
State Form TEST (27757) 04/08

INSTRUCTIONS: Please Print All Information in Blue or Black Ink

County of Residence of Applicant _____**Application Date** _____ Enrollment Date _____

CSHCS Key # _____ Effective Date _____ E-mail _____

Child Also Known As: _____

Applicant's Name _____DOB: _____
Last First MI

Medical Condition for applying to CSHCS: _____

Primary language spoken in home: English _____ Spanish _____ Other _____

Social Security # _____M ___ F ___ Race _____ Ethnicity _____

Current Address _____

City _____ZIP code _____

Home telephone ( ) _____ Work telephone ( ) _____

Parent/Guardian _____

Current Address _____

City _____ ZIP code _____

Home telephone ( ) _____ Alternate telephone ( ) _____

Work telephone ( ) _____

Parent/Guardian _____

Current Address _____

City _____ZIP code _____

Home telephone ( ) _____ Alternate telephone ( ) _____

Work telephone ( ) _____

Intake Personnel: _____

Site Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: ( ) _____ Fax: ( ) _____

HOUSEHOLD MEMBERS and INCOME INFORMATION

List all persons (including participant) who live in your home and provide requested information for each individual. This includes children who are in college.

Name	Relationship to applicant	DOB	Gender	Race	Ethnicity	SSN#	√ if applying for Hoosier Healthwise	Other Insurance Y/N

CSHCS Household Size: _____

Income Verification must be provided for everyone receiving income that is part of your household. Include copies of all documentation used to prove income. Preferred documentation is the most recent 1040 Federal tax form; however, if income has changed from last 1040 report, still provide the 1040, but also provide your 3 most recent consecutive check stubs and write a note of explanation. Other acceptable documentation is an Employer's letter (on company Letterhead) signed and dated, showing how much you earn and how often received. Attach additional sheet if necessary.

	1		2		3	
NAME OF PERSON RECEIVING INCOME →						
Wages/Fees/Commissions/Tips/Sick Benefits	Gross Amount	How Often	Gross Amount	How Often	Gross Amount	How Often
Social Security or SSD or SSI (SSI **NOT** counted as income for CSHCS, but must be reported)						
Dividends/Interest on Savings						
Unemployment Compensation/Strike Benefits						
Alimony/Child Support/TANF (provide documentation)						
Regular Contributions from persons not living in the household (provide name & statement)						
Other income not listed above includes: Trustee Assistance, Farm Income, Rental Income, Pensions, Annuities, Trusts, Royalties, Estates, and Military Compensation						

If you have no income, how do you pay your bills? (supply written & signed statements) _____

_____

Total Household Income $ _____

Income Documentation was verified by: _____ Date: _____

(Signature of Intake Personnel)

MEDICAL INSURANCE INFORMATION

Complete a <u>new</u> form for each insurance coverage.

1. PARTICIPANT IDENTIFYING INFORMATION:

Name: _____ D.O.B.: _____ CSHCS #: _____

Address: _____ _____ IN _____

Street City ZIP Code

2. HOOSIER HEALTHWISE INFORMATION – HOOSIER HEALTHWISE NUMBER: _____

Complete One: Current Coverage Effective Date: _____

Pending HHW Date: _____

Not Financially Eligible Date of Denial: _____

Medicaid Disability with/without spend down $_____
(if known)

3. POLICYHOLDER INFORMATION:

Name: _____ Relationship: _____ Telephone: ( ) _____

Address: _____

Street City State ZIP Code

4. INSURANCE COMPANY INFORMATION: ☐ **Primary** ☐ **Secondary**

Name: _____ Telephone: ( ) _____

Billing Address: _____

Street City State ZIP Code

Check As Applicable: Is this Coverage: ____ Through Employer ____ Self Purchase ____ Union ____ HMO Policy ____ PPO Policy

5. POLICY NUMBER: _____ Member/I.D. #: _____ Group/Acct. #: _____

Effective date dependent will be covered under policy: _____ Termination Date: _____

6. EMPLOYER INFORMATION:

Name of Employer: _____

Address: _____

Street City State ZIP Code

Telephone: ( ) _____ Start Date: _____

7. COVERAGE INFORMATION: Check As Applicable:

A. Second Insurance Company Coverage? ☐ YES ☐ NO

B. Therapy Services Covered: ☐ OT ☐ PT ☐ Speech

C. Co-Payments? ☐ YES ☐ NO

Office Visit Amt: $ _____ Specialist Amt: $ _____

Emergency Room Amt: $ _____ Other Amt: $ _____

Prescriptions Amt: $ _____ DME Services Amt: $ _____

D. Deductibles? ☐ YES ☐ NO If YES, Amt: $ _____

E. Maximum Out of Pocket Expense $ _____

F. Is there a pre-existing clause? ☐ YES ☐ NO

Effective Date: _____

G. Is there a dental plan? ☐ YES ☐ NO

Name of plan if different: _____

Effec. Date: _____ Term. Date: _____

H. Lifetime maximum? ☐ YES ☐ NO

$ _____ per person $ _____ per family

I. Conditions/Exclusions: _____

PROVIDER HISTORY INFORMATION

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Applicant's Name _____DOB: _____

Health care received in the past 12 Months (copy additional pages of this section as needed.) List the primary care physician for all well-child care including immunizations and illness. List the dentist (if applicable), clinics and other medical care providers by specialty type.

Name of Primary Care Physician:		Date Last Seen:
Address: City, State, ZIP	Telephone: ( ) Fax: ( )	
Reason(s) Seen:		
Name of Dentist:		Date Last Seen:
Address: City, State, ZIP	Telephone: ( ) Fax: ( )	
Reason(s) Seen:		
Name of Specialty Care Physician:		Date Last Seen:
Address: City, State, ZIP	Telephone: ( ) Fax: ( )	
Reason(s) Seen:		
Other Specialty Provider:	Hospital/ER	
Name:		Date Last Seen:
Address: City, State, ZIP	Telephone: ( ) Fax: ( )	
Reason(s) Seen:		
Other Specialty Provider:	Hospital/ER	
Name:		Date Last Seen:
Address: City, State, ZIP	Telephone: ( ) Fax: ( )	
Reason(s) Seen:		
Other Specialty Provider:	Hospital/ER	
Name:		Date Last Seen:
Address: City, State, ZIP	Telephone: ( ) Fax: ( )	
Reason(s) Seen:		
Other Specialty Provider:	Hospital/ER	
Name:		Date Last Seen:
Address: City, State, ZIP	Telephone: ( ) Fax: ( )	
Reason(s) Seen:		

MEDICINES and MEDICAL EQUIPMENT

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What type(s) of adaptive equipment is currently used by your child? (√ accordingly)

☐ Wheelchair ☐ Walker ☐ Splints/AFO's (ankle, foot, orthosis) ☐ Eye Glasses
☐ Adaptive Seating ☐ Adaptive Bathing ☐ Assistive Communication Device(s) ☐ Braces
☐ Feeding Aids ☐ Hearing Aids ☐ Other:_____

What medical, health equipment or supplies are routinely used by your child? (√ accordingly)

☐ Apnea Monitor ☐ Oxygen ☐ Prescription Drugs ☐ Tube Fed
☐ Ventilator Dependent ☐ Other:_____

Current Medications (specify dose, frequency and purpose)

Medication	Dosage	Frequency	Purpose

Is the applicant currently on a special diet? ☐ YES ☐ NO Type: _____

Additional Comments: _____

_____

_____

_____

_____

Application for Enrollment
Children's Special Health Care Services (CSHCS)
State Form TEST (27757) 04/08

INSTRUCTIONS FOR COMPLETING THIS FORM:

1. Applicant must sign all copies in ink in the presence of the person authorized to accept the application who may be an employee of the Indiana State Department of Health, the County Division of Family and Children, Family and Social Services Administration and/or any other entity approved by the Director.
2. Once completed and signed, an application shall never be altered by the applicant or by an employee or designee of the State Department, County, or Family and Social Services Administration. No application shall be destroyed unless proper legal procedures are followed. Provide a copy to parent, file, and send original or copy to CSHCS and/or MCH programs with completed enrollment forms.

PARTICIPANT RIGHTS INCLUDE:

1. Fair treatment regardless of race, color, creed, national origin, age, gender, or disability.
2. An administrative hearing may be requested. Any decision affecting your participation in CSHCS, which you do not agree with, can be reviewed. You must request a hearing within 15 days from the day of notice of the decision. You shall do this in writing. More information on the hearing process will be given to you, in writing, at the time the decision is made.

STATEMENT OF AGREEMENT:

In support of this application, I will, when requested, supply such information as I can to persons authorized to request and receive it.

I hereby certify that all of the information in the Combined Enrollment Form, including the verified income, is true and correct.

I hereby give consent for routine health care, diagnostic evaluation and medical treatment under Children's Special Health Care Services and/or Maternal and Child Heath Services. I understand that I must use all available health insurance and/or Medicaid coverage for the child's healthcare before the Indiana State Department of Health makes any payments. In the event that the insurance payment is made directly to my spouse, or me I will pay said payment to the Indiana State Department of Health as a repayment for costs paid by the Department.

I understand that the availability of and the provision of health care services included in the basic service component and the limited service component is contingent upon the availability of program funding.

I hereby consent to the release of personal and financial record information on this form to the Indiana State Department of Health for the purposes of verifying eligibility and performing program evaluations.

I, being the applicant (parent or legal guardian) understand the application date for enrollment in the Children's Special Health Care Services Program will be the date of this signature as long as I provide the financial and social information necessary to complete this application, within the thirty days, to the CSHCS Program Designee (interviewer completing this application). I understand that if I do NOT provide this information, this application will be denied for failure to cooperate in the application process. I understand that I will be required to initiate a new application with updated information and sign a new signature page if I want to go forward with the application process. The new signature date will become the date of the application and the effective date will be adjusted accordingly.

I understand that the approved health and welfare agencies of the Indiana State Department of Health will maintain confidentiality of this information pursuant to IC 16-39, IC 5-14-3-4(a)(9), 42 CFR§51a, 112, and 7CFR§246.26(d).

Participant's Name (*****May sign for self if over 18 years of age or older)

*****Signature of Participant/Parent/Legal Guardian	Relationship to Applicant	Date
Signature of Participant/Parent/Legal Guardian	Relationship to Applicant	Date
Signature of Intake Personnel		Date

Authorization For The Collection Of Information
Children's Special Health Care Services

State Form TEST (27757) 04/08

PLEASE REVIEW THE FOLLOWING INFORMATION AND HAVE YOUR INTAKE or SERVICE COORDINATOR DISCUSS ANY QUESTIONS THAT YOU MAY HAVE BEFORE SIGNING BELOW.

Applicant's Name: _____ DOB: _____

We are asking for your permission as parent/legal guardian/emancipated minor/person 18 years of age or older, to collect demographic and service information about you and/or your child and store it electronically in the Indiana State Department of Health (ISDH) and/or Family and Social Services Administration (FSSA) database system(s).

The program you are enrolling in is the Maternal and Children's Special Health Care Services, a program that provides the primary, specialty, diagnostic and dental-related care for medically and financially eligible children 0-21 years of age. Services available through this program include screening, evaluation and assessment, service coordination, due process and procedural safeguards, health and medical services that are made available based upon the needs of the child and family.

This authorization covers certain medical ("Protected Health Information"), social and financial information about the eligible child and family, unless an exception is noted below, including: child/family demographic information; health visit information; infant/child visit data; disability/risk factors; problems or factors that prevent the eligible child and family from receiving appropriate services or medical care; appointments made and services received; Individualized Family Service Plan (IFSP) activities, care plans and family financial eligibility information.

Based upon the information collected during the eligibility determination and enrollment process, a multidisciplinary team will work with you to determine your child's needs for services. With your informed, written authorization, only those health care professionals and service providers with a direct need to know and with authorized security clearance will have access to the electronic file or authorizations for eligibility determination services that are required and authorized by you as your child's parent/legal guardian. Statistical and program information, without any child or family identifying information, will be sent to State and Federal agencies that fund these services to meet various reporting requirements.

Individually designated and signed releases are maintained in your child's record at the local System Point of Entry/ISDH/MCH clinics that indicate individuals with whom you have given your informed, written authorization for reciprocal communications including the sharing and receipt of reports. The person(s) receiving this information has a legal and ethical duty to keep the information in a confidential and private manner, and will not release it to anyone else without your written permission unless allowed by law.

By signing this authorization form, you agree to allow information to be collected through the System Point of Entry or state intake personnel for the electronic database collection systems. All aspects of the data collection, maintenance and utilization are protected under the Family Education Rights and Privacy Act (FERPA). All personal information collected will be treated as confidential pursuant to IC 4-1-6 et seq., IC 5-14-3-4 and 410 IAC 3.2-10, 42 CFR §51a. As the parent/legal guardian, access to information stored in the database is also available to you upon request for inspection or copying. As legal guardian, you authorize the ISDH and/or FSSA database system(s) to distribute information collected during the eligibility determination/enrollment process and service delivery period to the following:

1. Indiana Family and Social Services Administration, the Division of Disability, Aging and Rehabilitation Services, First Steps, and Hoosier Healthwise
2. Indiana Department of Education
3. Indiana State Department of Health
4. U.S. Departments of Education, and Health and Human Services, for the purposes of financial/program audit and monitoring purposes as required by various federal and state regulations.

By signing this authorization, I acknowledge that I have read and understand the information for collection and sharing of data contained on the forms. The authorization will remain in effect no longer than 12 months from the date of my signature. **I understand that I have the right to revoke this authorization, if the revocation is in writing, except to the extent that action has been taken in reliance on this authorization.**

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by law.

_____

Signature of parent/legal guardian/applicant (if 18+ or is an emancipated minor) Date

_____

Signature of Intake Personnel Date

INDIANA STATE DEPARTMENT OF HEALTH
CHILDREN'S SPECIAL HEALTH CARE SERVICES

Authorization for Release of Protected Health Information

I hereby authorize the Children's Special Health Care Services program of the Indiana State Department of Health and any of its employees and agents, to disclose confidential information about the applicant identified below.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.

1. Applicant Information

Last Name	First Name	Middle Initial
Last Four Digits of Social Security Number	Birth Date (MM/DD/YYYY)	Daytime Telephone Number (*include area code)*
Street Address	City, State and Zip Code	

2. I authorize the entity(ies) and its agents identified below to receive confidential health information pertaining to the applicant above.

Entity authorized to receive confidential information	Daytime Telephone Number (*include area code)*
Street Address	City, State and Zip Code
Entity authorized to receive confidential information	Daytime Telephone Number (*include area code)*
Street Address	City, State and Zip Code
Entity authorized to receive confidential information	Daytime Telephone Number (*include area code)*
Street Address	City, State and Zip Code

3. Purpose of this Authorization (check all that apply)

□ This authorization is for the purpose of processing the application and accompanying documents and records to determine the Applicant's eligibility for the Children's Special Health Care Services program of the Indiana State Department of Health and authorizes communication between said program's employees and agents and the entity(ies) named in section 2 above.

□ This authorization is only for requests for the following specific information:

_____

_____

_____

_____

If this authorization is limited to information in effect for a specific period of time, please indicate:

_____ through _____

mm/dd/yyyy *mm/dd/yyyy*

4. Description of the information to be released or disclosed: (*check all that are appropriate*)

□ Application or enrollment information.
□ Other: (*please specify*)

_____

_____

_____

5. IMPORTANT: Your signature below means that you understand and agree to the following:

- The protected health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, and/or communicable diseases, including HIV/AIDS. These records will be included in the information we will make available to the entity(ies) identified in Section 2 above.
- Information disclosed under this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations.
- Your eligibility for benefits and payment for services will not be affected if you do not sign this form. (However, without your signature, we will not be able to communicate with the entity(ies) identified in Section 2 for the purposes of processing your application.)
- This authorization will expire after the eligibility status of the Applicant has been determined or one year from the date you sign this authorization, whichever event occurs first. If you sign this form, you may revoke the authorization at any time by notifying the Children's Special Health Care Services of the Indiana State Department of Health in writing at the address below. Revoking this authorization will not affect any actions that took place in reliance on the authorization before we received notification.

6. Signature of Applicant's Parent or Legal Representative

Signature of Applicant's Parent (if Applicant is an unemancipated minor child), Or Applicant's Legal Representative	Date
Print Name	
Describe the relationship to the Applicant: □ Natural or Adoptive Parent of Un-emancipated Minor Child □ Legal Representative (i.e. someone with authority to act on the Applicant's behalf)	

Return this completed form with the Application to:

Indiana State Department of Health
Children's Special Health Care Services
Section 7B
2 North Meridian Street
Indianapolis, Indiana 46204

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

Authorization To Release And Share Medical Information
Children's Special Health Care Services

State Form TEST (27757) 04/08

PLEASE REVIEW THE INFORMATION ON THE REVERSE SIDE OF THIS FORM, AND HAVE YOUR INTAKE/SERVICE COORDINATOR DISCUSS ANY QUESTIONS THAT YOU MAY HAVE BEFORE SIGNING BELOW.

I/We, _____ hereby authorize:
Parent/Legal Guardian Name(s)

_____
Physician/Health/Medical Care Provider or Facility Name

_____
Practice/Hospital (as applicable)

_____
Street Address/Post Office

_____
City/Town State ZIP Code

To communicate and to share information including medical ("Protected Health Information"), in writing and conversation, with the First Steps Early Intervention Service System and Children's Special Health Care Services regarding:

_____
Child's Legal Name Date of Birth

_____
Street Address/Post Office

_____
City/Town State ZIP Code

This authorization includes the following types of information: (as checked √)

_____ Medical record information including but not limited to: progress notes, laboratory and x-ray reports, history and physical, discharge summary and treatment plan(s)

_____ Written specialty reports including assessments

_____ Medical record information required to determine eligibility, participate in service planning, and/or provide early intervention services as defined in the Individualized Family Service Plan (IFSP)

I HAVE READ AND UNDERSTAND THE CONDITIONS OF THIS RELEASE, AS CONTAINED ON THE REVERSE SIDE OF THIS FORM.

_____ _____
Signature (Participant if over 18 years of age) Date

_____ _____
Signature (Parent/Legal Guardian) Date

_____ _____
Signature of Intake Personnel Date

- OVER -

Authorization To Release And Share Medical Information
Maternal And Children's Special Health Care Services
State Form TEST (27757) 04/08

INSTRUCTIONS: Please read this carefully before signing. If you have questions, please ask your service coordinator care coordinator (if applicable)

The purpose of this release is to collect information necessary to determine the participant's eligibility for the programs listed above, and to plan and provide essential and necessary services as determined through the multidisciplinary team process. I hereby authorize the medical provider named on this form to release to the staff of Maternal and Child Heath Services, and/or Hoosier Healthwise, and/or First Steps and/or Children's Special Health Care Services upon presentation of this form, any records or information pertinent to the development and implementation of a plan for service to meet the medical, educational, developmental, social, and rehabilitative needs for the participant named on this form. Authorization is also granted for release of information by Maternal and Child Heath Services, and/or Hoosier Healthwise, and/or First Steps and/or Children's Special Health Care Services to accomplish referrals for service to other individuals where an informed, written consent has been obtained from me as the parent/legal guardian; and to ensure ongoing service delivery in accordance with the IFSP through routine communications including report distribution, participation in IFSP meetings, and planning and review activities.

I understand that this consent includes the sharing of information as authorized above in written, verbal, and/or video format. As the parent/legal guardian, or surrogate parent (for educational purposes only, in the event one is appointed for early intervention services), I understand that I may revoke this authorization shown on the reverse of this form at any time in writing. The request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first. A copy of this "Authorization to Release and Share Medical Information" has the same effect as an original.

The information collected as a result of this consent shall be maintained in the participant's record which will be located at Maternal and Child Health Services, and/or the Indiana Hoosier Healthwise, and/or First Steps, and/or Children's Special Health Care Services. This record is subject to the provisions of the Family Educational Rights and Privacy Act (FERPA) and Release of Medical Records Law IC 16-39, as such, is available for my review and may be reproduced or corrected upon my request. All personal information collected will be treated as confidential pursuant to IC 4-1-6 et seq., IC 5-14-3-4 and 410 IAC 3.2-10.

Physician's Health Summary

Children's Special Health Care Services

State Form TEST (27757) 04/08

INSTRUCTIONS: Your patient is currently in the evaluation process for eligibility for CSHCS and/or early intervention services under Part C of the Individuals with Disabilities Education Act (IDEA). All components of this evaluation are required to be completed within 45 days. The health summary request is an initial step in this process. Your participation in the evaluation to determine the child's eligibility is requested by completing and returning this form in the enclosed envelope. If you have questions, please contact the Intake/Service Coordinator listed on the cover letter. Your participation in this activity is greatly appreciated.

IDENTIFYING INFORMATION

Child's Name: _____ D.O.B.: _____

Parent/Guardian: _____

MEDICAL INFORMATION

Birth Place: _____ Birth Weight: _____ (grams) _____ (lbs/oz) Apgar _____ Gestational Age: _____

Length of Hospital Stay: _____ Past Hospitalizations/Illnesses: _____

_____

***ADDITIONAL COMMENTS* (please include any recommendations you may have):** _____

_____

CURRENT HEALTH STATUS

Present **diagnosis/illnesses** including ICD/DSM CODE(S): _____

_____

Current Medications and frequency : _____

_____

Medical Precautions: _____

Physical Status: _____ _____

Vision: _____ Hearing: _____

Date Screened/Tested: _____ Date Screened/Tested: _____

Developmental Screening: Date: _____ Results: _____

Date Last Seen: _____ Other Physician Referrals Made: _____

If indicated, I authorize the above named child to be seen as follows:

_____ Physical therapy evaluation, as indicated

_____ Occupational therapy evaluation, as indicated

_____ Speech therapy evaluation, as indicated

_____ _____

Physician's Signature (Primary/Specialty Health Provider) Date

_____

Physician's Name (Please Print)

_____

Physician's Address/Telephone #

Return to: **ISDH/CSHCS**
2 N Meridian St., Section 7B
Indianapolis, IN 46204

Telephone: 1-800-475-1355
Fax: 317-233-8462

Application for Hoosier Healthwise for Children and Pregnant Women
State Form 43202 (R5 / 6-05)
FI 2030

HOOSIER HEALTHWISE

for Children & Pregnant Women

1. Tell us about the members of your family living in your household. Put your name first, and list only children, spouses, and parents. Place a ✓ in the last column if that person is applying for health coverage.

Name (*First, MI, Last*)	Date of Birth *(month, day, year)*	Social Security Number *(See #6 on 2nd page)*	Marital Status	Race	Sex	Relationship to You	Citizen of U.S. Yes / No *(See #8 on 2nd page)*	✓ if applying

2. Tell us your address and telephone number.

Home address	City	State	ZIP code	County	Telephone number
Mailing address, *(if different)*	City	State	ZIP code	County	Other contact number

3. Do the applicants live in Indiana? ☐ Yes ☐ No

4. Does any applicant have a court-appointed legal guardian? ☐ Yes ☐ No **If so, who?** _____

5. Are any of the applicants pregnant? ☐ Yes ☐ No

Name of expecting mother	Date pregnancy began *(month, day, year)*	Due date *(month, day, year)*	Number of unborn babies

6. Are any of the applicants blind or disabled? ☐ Yes ☐ No ***(Enter a ✓ for blind or disabled)***

Name of applicant	Blind	Disabled	Name and address of the doctor

7. Are any of the applicants covered by health insurance now? ☐ Yes ☐ No
If yes, who? _____

8. Did any applicants who do not have health insurance lose their coverage in the past 3 months? ☐ Yes ☐ No
If yes, who? _____ **When did coverage end?** _____

Please tell us why coverage was lost by putting a ✓ beside the reason(s).

☐ Loss of employment ☐ Coverage limit reached ☐ Non-custodial parent dropped insurance ☐ Divorce
☐ Could not afford ☐ Company ended coverage ☐ Other Specify:

Completed by Enrollment Center: Date of application: *(month, day, year)* _____ Center's Code: _____ Interviewer: _____

Completed by DFR: Date received: (*month, day, year)* _____ Case number: _____

9. Tell us how much work income you and other members of your family make.

Name of person working _____	Name of person working _____
Start date: *(month, day, year)* _____ End date: *(month, day year)* _____	Start date: *(month, day, year)* _____ End date: *(month, day, year)* _____
Amount of gross pay per period: _____	Amount of gross pay per period: _____
How often paid? ☐ Weekly ☐ Bi-weekly ☐ Monthly	How often paid? ☐ Weekly ☐ Bi-weekly ☐ Monthly
☐ Twice a month ☐ Other Hours worked a week: _____	☐ Twice a month ☐ Other Hours worked a week: _____
Do hours vary? ☐ Yes ☐ No Is person self-employed? ☐ Yes ☐ No	Do hours vary? ☐ Yes ☐ No Is person self-employed? ☐ Yes ☐ No
Name of employer and telephone number	Name of employer and telephone number

10. Tell us if you or any family members receive other income from the types listed here. If your family has no income, initial here _____ . (*For child support, put the child as the person receiving it.*)

1. SSI
2. Social Security
3. Veteran's Benefits
4. Railroad Retirement
5. Pension
6. Military Allotment
7. Unemployment
8. Support (*alimony or child support*)
9. Sick Benefits
10. Strike Benefits
11. Interest Payments
12. Educational Income
13. Cash from Friends, Relatives, etc.
14. Worker's Compensation
15. Other? Please specify: _____

Name of the Person Receiving the Payments	What Type (*from above*)	How Often are Payments Received	When did Payments Begin	Amount of the Payments

11. Was the household income in the prior 3 months the same as it is now? ☐ Yes ☐ No If no, please explain:

_____

_____

12. Do you pay for child care? ☐ Yes ☐ No Do you pay for care of an incapacitated adult? ☐ Yes ☐ No

13. Does anyone living in the household pay support payments? ☐ Yes ☐ No

14. Assignment of Rights. *I hereby assign to the state of Indiana, my rights to medical support and payments for medical care which I have on behalf of myself and other persons under this application whose rights I can legally assign.*

(*Signature*) _____

15. Please read the following statements and initial if you agree, and sign your application below.

_____ I certify under penalty of perjury, that all the information I have provided is complete and correct to the best of my knowledge and belief and that I have received the notice entitled "Important Information about Hoosier Healthwise" and understand what it states.

_____ If the children applying for health coverage on this application, are found to qualify for Package C - Children's Health Plan, I agree to pay the premiums and co-payments that are required.

Your signature: _____ **Date:** ***(month, day, year)*** _____

Signature of witness if signed with "X" _____

All Hoosier Healthwise members need to choose a primary care doctor. To choose a doctor or to find out more about the doctors in your area, call the Hoosier Healthwise Helpline at 1-800-889-9949.