

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS
Kansas Department of Health and Environment - Bureau of Family Health
1000 SW Jackson, Suite 220, Topeka, Kansas 66612-1274
(785) 296-1313 or (Toll Free) 1-800-332-6262
Fax 785-296-8616

TO SPEED UP YOUR APPLICATION, PLEASE

1. Fill out the **ENTIRE** application: make sure you sign and date pages 3 and 4.
2. On page 4, fill in the names and addresses of doctors, hospitals, etc., that are providing care for the person you are applying for. This form **MUST** have the signature of a witness. The witness can be a spouse, neighbor, friend or almost anyone.
3. Attach copies of the following:
 - (a) The 1st page of your last Federal income (1040 or 1040A) tax form and W-2's.
 - (b) **If you have changed jobs since your last W-2**, send in copies of pay stubs for the last six (6) pay periods or an employer's statement of anticipated earnings, plus your tax form.
 - (c) **If you are self-employed**, send in your last quarterly estimated tax form or copies of expenses & income for the last (3) three months.
 - (d) **If you are receiving other income from anyone in the household such as Unemployment Benefits, Social Security Payments, Disability Payments, SRS Assistance, Child Support, etc., please send verification.**
 - (e) **If you are divorced**, please send a copy of your divorce papers showing custody of the person you are applying for.
4. If you or the person you are applying for is known by any other name, please list all other names.
5. Please send a copy of the applicants birth certificate if **not** a US citizen or US legal resident.
6. Mail completed application and the required information in the enclosed envelope provided.

After reviewing your application, we may need to send you a letter for additional information, such as bills owed, financial verification from other members in the household, guardianship papers, etc.

IF YOU NEED ASSISTANCE COMPLETING THIS APPLICATION,
PLEASE CONTACT OUR OFFICE AT THE TELEPHONE NUMBER ABOVE.

**CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS - (SPECIAL HEALTH CARE NEEDS- CYSHCN) APPLICATION
GENERAL INFORMATION**

NAME OF APPLICANT (Child, unless applying for self) LAST FIRST MIDDLE	BIRTH DATE	SEX	SOCIAL SECURITY NUMBER	MOTHER'S MAIDEN NAME
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Home Address:	Apt #:	City:	ST:	Zip:	CO:
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APPLICANT'S DIAGNOSIS AND REASON FOR APPLYING:

APPLICANT'S PRIMARY CARE PHYSICIAN Name	Address:	Phone #:
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Name of Medical Specialists Seeing Applicant	Address	Date Last Seen

Current Medications:	Name and Address of Pharmacy
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SCHOOL OR EARLY INTERVENTION PROGRAM: NAME:	Address:	Phone:	School Dist#:
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SPECIAL SERVICES/EARLY INTERVENTION SERVICES: OT PT SPEECH Counseling OTHER (PLEASE LIST) _____

MARITAL STATUS OF PARENTS: MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> REMARRIED <input type="checkbox"/>	DO YOU SPEAK ENGLISH? YES <input type="checkbox"/> NO <input type="checkbox"/> If no, language spoken _____ Contact Person who Speaks English Name: _____ Phone: _____
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NAME OF PARENT(S) (where child lives)	(Check box to indicate if Step-Parent)	HOME PHONE OR NUMBER WHERE YOU CAN BE CONTACTED:
LAST FIRST MI		
FATHER	<input type="checkbox"/>	
MOTHER	<input type="checkbox"/>	

Name of Parent NOT Living with Child	Home Phone or Number Where You Can Be Contacted:
LAST: FIRST: MI:	
Address: Apt#: City: ST: Zip: CO:	

Name of Legal Guardian if Different from Parent	Home Phone or Number Where You Can Be Contacted:
LAST: FIRST: MI:	
Address: Apt#: City: ST: Zip: Co:	

CYSHCN: _____	DIAGNOSIS: _____	APPL DATE _____	ACCEPT DATE _____	CLOSE DATE _____	CSHCN	SSI	FOR CYSHCN USE ONLY
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List all the people living in the household (related and not-related)

NAMES (Attach extra sheet, if needed)		Relationship to the Applicant	Date of Birth	Applied for Healthwave /Medicaid? Yes/No	Name of Insurance Company	Policy and Group Number	Annual Premium (\$ Amt)	Deductible per Family/ Individual	Dental Coverage Yes/No	Restrictions	Start Date	Receivi ng SSI? Yes/No
Last	First											
1.		(Applicant)										
2.												
3.												
4.												
5.												
6.												
7.												
8.												
9.												
10.												

Is applicant a US Citizen? Yes No

Is applicant a legal resident of the US? Yes No

Other Health Insurance Coverage Available for Applicant (Available Such As From Parent Not Living at Home or Grandparent)

Names (Attach extra sheet, if needed)		Relationship to the Applicant	Name of Insurance Company	Policy and Group Number	Annual Premium (\$ Amt)	Deductible per Family/ per Individual	Restrictions	Major Medical Yes/No	Dental Coverage Yes/No	Start Date	End Date
Last	First										
1.											
2.											

FAMILY'S RESPONSIBILITIES

I hereby agree to:

- Apply for the insurance benefits and assign those benefits to the hospital, physician and suppliers of equipment and medical items ordered by the attending physician.
- Apply for insurance benefits of any non-assignable insurance by making payment to the hospital, physician and suppliers of equipment and medical items ordered by the attending physician.
- Repay Children and Youth with Special Health Care Needs, any insurance proceeds sent directly to me, if the insurance payment is made for treatment or equipment provided and paid for by Children and Youth with Special Health Care Needs.

I also agree to notify Children and Youth with Special Health Care Needs within 10 days of the following:

- The applicant acquires health insurance.
- The applicant becomes eligible for Medicaid, Supplemental Security Income, Disability Payments, Welfare Payments, or
- Changes in the applicant's address, income, marital status, custody of children, family income or cash assets of \$500 per year or other circumstances that affect the applicant or eligible person.

Signature of applicant/parent or legal guardian (if applicant is a child)

Relationship to Applicant

Date

APPLICANT'S NAME:

BIRTHDATE:

List all the income received by people living in your household (related and non-related)

Be sure to include all sources of gross income (before taxes) such as wages, dividends, and interest, Assistance from SRS (TAF, food stamps), SSI, annuities, pensions, disability, child support, alimony, and other unearned income

Name of person(s) working or receiving money. Attach extra sheet, if needed	Who provides the money? Name of Employer, Program or Person, Please Specify.	Work Phone Number	How often? Weekly, Every 2 Weeks, Twice a Month, or Monthly.	What Amount? (GROSS)
1.				
2.				
3.				

List all the cash assets for all people living in your household (include cash, checking/savings accounts, certificates of deposit, stocks and bonds)

Types of Resources	Whose	Value
1.		
2.		
3.		

Are there any circumstances that will make this year's expected income different from that reported on your last year's income tax? Yes No
If yes, please describe the changes (Examples: change in marital status, loss or change of job, overtime, etc.) and provide wage verification, pay stubs:

Describe current and expected medical needs and estimated costs for child that you are responsible for payment.

Describe current and expected medical needs and estimated costs for other family members that you are responsible for payment.

Requested Information Regarding the Applicant*

Race: White Black/African American American Indian or Native Alaskan Asian Native Hawaiian or Other Pacific Islander Other (specify) _____

Ethnicity: Hispanic or Latino

* The answer will not effect eligibility. The answer will be used only to collect information about people who apply for the program.

Services are provided on a nondiscriminatory basis in accordance with regulations of the Department of Health and Human Services and Title VI of the Civil Rights act of 1964. Any person who believes that discrimination on the grounds of race, color or national origin is being practiced, has the right to file a complaint with the Kansas Department of Health and Environment or the Department of Health and Human Services or with both.

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 CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN)
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Release of Information Consent

Applicant's Name: _____	Birth date: _____
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I give permission to Children and Youth with Special Health Care Needs (Special Health Care Needs, CYSHCN) to obtain medical, education and other relevant information from the following physicians, hospitals, schools and others who have provided services for the above named individual.

DOCTOR OR HOSPITAL	ADDRESS	CITY	ST	ZIP

I understand that this consent is effective for one year from the date signed.

I authorize KDHE/CYSHCN to share medical information with other agencies and contractors for the purpose of quality assurance and to ensure appropriate services are provided.

 Signature of parent, guardian, applicant if over age 18, or authorized representative Date

 Signature of Witness (Required)

A COPY OF THIS CONSENT FORM IS AS VALID AS AN ORIGINAL.

 To Be Completed by CYSHCN staff Date Requested: _____

Information being requested: Medical record information _____ Hospital Discharge summaries _____
 Medical record information since _____ Other _____

***NO LAB OR X-RAY REPORTS UNLESS REQUESTED.**