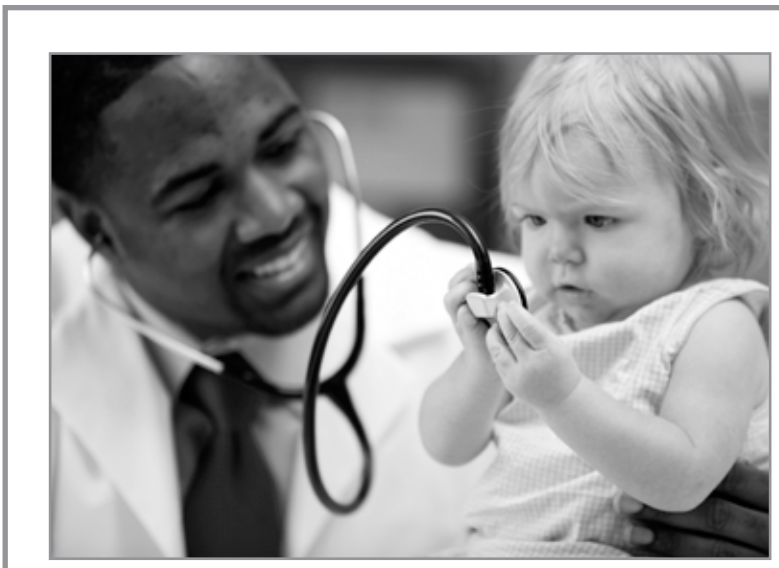
CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) SERVICES PROGRAM

Client Application Form



www.dshs.state.tx.us/cshcn

TEXAS Department of State Health Services

Form T-3
Rev. 03-2013

CSHCN

There are symbols you will see in these pages.

This symbol means that we need to tell you more about the item.

- There are several items that you need to send us.
- Look at the list for the item and mark the one you are sending as proof.

Instructions

- Print in blue or black ink only.
- Fill in all blanks.
- Complete all pages as needed.
  - You may not have to fill out page 9.
- Sign and date page 10.
- Have your doctor or dentist fill out the form that starts after page 15.
- You will need to send the doctor's form with your **first** application AND
  - every 12 months after that or
  - any time your health changes.
- Send your application and the doctor's form to the program office in your area.
  - Include all the proofs we ask for. Your application is complete only if you send all the pages and proofs we need.
  - Put the name and date of birth of the person who needs our help on all copies of the things you send to us.

To find your local program office:

1. Find the name of the county where you live in the list on page 14.
2. After the county's name, you will see a code of numbers and letters.
3. Find the code in the list on page 15. That is your local office.

It is a good idea to make copies of all the papers you send to us. You will have to renew your application every 6 months if you become our client.

Children with Special Health Care Needs (CSHCN) Services Program
Client Application Form

LOOK!

- **Print in blue or black ink only.**
- **Fill in all blanks.**
- **Complete all pages.**

Mark one: This application is ☐ my first ☐ a renewal

We need a way to contact you.

1. Give us your name and how to contact you.
2. Tell us about another adult we can call if we cannot reach you.

ADULT 1

First Name _____ **M.I.** ____ **Last Name** _____

Relationship to Applicant: ☐ Parent ☐ Self ☐ Guardian ☐ Other _____

ADULT 2

First Name _____ **M.I.** ____ **Last Name** _____

Relationship to Applicant: ☐ Parent ☐ ☐ Guardian ☐ Other _____

Can we contact you by email?

☐ No

☐ Yes ▶ **What is your email address?** _____

What are your phone numbers?

Home phone (___) _____ Work phone (___) _____

Cell phone (___) _____ Other phone (___) _____

What language do you prefer?

☐ English ☐ Spanish ☐ Vietnamese

☐ Other _____

What is your home address?

Street _____ Apt. ____ City _____ ZIP _____

The proof you use MUST show these two things:

1. **this address**
2. **the name of one of the adults shown on page 1**

- ☐ **Valid Texas Driver License or ID Card**
- ☐ **Rent receipt or mortgage payment dated in the last 60 days**
- ☐ **Current lease**
- ☐ **Texas Motor Vehicle Registration for current year**
- ☐ **Valid Texas Voter Registration**
- ☐ **Electric, gas, water, or any phone bill, dated in past 60 days**
- ☐ **Any current Medicaid ID**
- ☐ **Any current CHIP Health Plan Card that shows the address where you live**
- ☐ **School records for current school year (Call your local office for a form.)**

If you get your mail somewhere else, put that address here:

Address _____ City _____ ZIP _____

Tell us about the person who needs our help:

If there is more than one person in your family who needs our help, make copies of this page for EACH person.

First Name _____ M.I. ____ Last Name _____

☐ Female ☐ Male

CSHCN Client Number _____

LOOK! **Leave this blank if this is your first application.**

U.S. citizen? ☐ Yes ☐ No

Permanent legal resident? ☐ Yes ☐ No

If this person has a Social Security number, put it here: _____

SEND US PROOF

Date of birth _____ mm/dd/yy

You only need to send in proof of date of birth with your FIRST application. Check one below.

- ☐ **Birth certificate**
- ☐ **Passport**
- ☐ **Bureau of Vital Statistics Record**
- ☐ **Adoption papers or records**
- ☐ **Any Medicaid ID form**
- ☐ **CHIP Health Plan card**
- ☐ **Hospital or public health birth record**
- ☐ **Indian (Native American) census record**
- ☐ **Record from U.S. Citizenship and Immigration Services**
- ☐ **Paternity Records from Office of Attorney General**
- ☐ **Social Security Adminsitration records**
- ☐ **Court or child support orders**
- ☐ **School or day care records (Call local office for a form.)**

Does this person live at the home address shown on page 2?

☐ Yes

☐ No ▶ Where does this person live?

☐ Foster home ☐ ICF-MR Facility ☐ Nursing home _____ name

☐ Other _____ name

LOOK!

If the applicant is homeless, call your local Program office to find out what to do. See pages 14-15 to find your local office.

Who earns income in your home?

1. Mark one of the boxes.
2. Fill in the items below the box you mark.

☐ **No one in my home gets an income.**

▶ Who in your home last had an income?

_____ ____ _____
First Name **M.I.** **Last Name**

▶ What is the last date worked? _____

▶ Are you getting unemployment benefits? ☐ No

☐ Yes ▶ Include the amount below.

▶ Initial here that what you put above is true: _____
INITIALS

☐ **We get income from these sources (add more pages if you need them):**

▶ Income source 1: _____
(Employer)

▶ Amount earned: _____ every: ☐ week ☐ month ☐ two weeks

▶ Who in your home gets this income?

_____ ____ _____
First Name **M.I.** **Last Name**

▷ Income source 2: _____
(Employer)

▷ Amount earned: _____ every: ☐ week ☐ month ☐ two weeks

▷ Who in your home gets this income?

_____ ____ _____
First Name **M.I.** **Last Name**

▶ Income source 3: _____
(Employer)

▶ Amount earned: _____ every: ☐ week ☐ month ☐ two weeks

▶

_____ ____ _____
First Name **M.I.** **Last Name**

LOOK!

- **Your income includes child support, unemployment, pensions and SSI benefits.**
- **Your income does NOT include social security payments a child gets.**
- **You MUST send in proof of all income people in your home get. (See next page.)**

SEND US PROOF

You must send proof of every income on page 4.

1. Find the types of income you put on page 4.
2. Send in a copy of **one** of the items shown for **each** income source.

1 Job

- ☐ Paycheck stub
  - Dated in the last 60 days
  - Shows the gross amount earned
- ☐ Signed and dated letter from employer
  - Says how much and how often you are paid
  - Dated in the last 60 days
- ☐ Medicaid Income Verification Form 1028
  - Dated in the last 60 days
- ☐ CSHCN Services Program Employment Verification Form
  - Dated in the last 60 days
  - Call the local Program office or 1-800-252-8023 to get this form.

2 Self-employment

- ☐ Signed and dated income tax return that shows your adjusted gross income
  - Use the return for last year if today's date is April 15 or before.
  - Use the return for this year if today's date is after April 15.
- ☐ Statement of Self-Employment Income Form, dated in the last 60 days
- ☐ Receipts of what you spent and earned in the last 60 days

3 Child Support

- ☐ Most current filing of Divorce Decree that shows amount
- ☐ Most current Attorney General Office document that shows amount
- ☐ Cancelled check showing payment in the last 60 days

4 Unemployment or worker's compensation

- ☐ Award letter dated in the last 60 days

5 VA or retirement benefits, or railroad pension

- ☐ Bank statement from last 60 days showing direct deposit

6 SSI (Do not include SSI a child gets)

- ☐ Bank statement from last 60 days showing direct deposit
- ☐ Most recent SSI check or SSI award letter dated in the last 60 days

Who lives with the person who needs our help?

If there are more than 5 people, make copies of this page.

1

First Name _____ **M.I.** ____ **Last Name** _____

☐ Parent ☐ Guardian ☐ Spouse

☐ Sister ☐ Brother ☐ Other _____

Date of Birth: _____
mm/dd/yy

2

First Name _____ **M.I.** ____ **Last Name** _____

Relationship to Applicant: ☐ Parent ☐ Guardian ☐ Spouse

☐ Sister ☐ Brother ☐ Other _____

Date of Birth: _____
mm/dd/yy

3

First Name _____ **M.I.** ____ **Last Name** _____

Relationship to Applicant: ☐ Parent ☐ Guardian ☐ Spouse

☐ Sister ☐ Brother ☐ Other _____

Date of Birth: _____
mm/dd/yy

4

First Name _____ **M.I.** ____ _____

Relationship to Applicant: ☐ Parent ☐ Guardian ☐ Spouse

☐ Sister ☐ Brother ☐ Other _____

Date of Birth: _____
mm/dd/yy

5

First Name _____ **M.I.** ____ **Last Name** _____

Relationship to Applicant: ☐ Parent ☐ Guardian ☐ Spouse

☐ Sister ☐ Brother ☐ Other _____

Date of Birth: _____
mm/dd/yy

Tell us about your costs for child care.

If there are more than 4 children, make copies of this page.

LOOK!

If you do <u>not</u> pay for child care

1. Mark the box to the right. → ☐ **I do not pay for child care.**
2. Go to the next page.

If you pay for child care, fill in this page with the:

A. Child's name
B. Amount you pay for child care
C. Person or center you pay for child care

1

_____ ____ _____
Child's First Name **M.I.** **Last Name**

Amount you pay each month: _____

Name of person or child care center you pay: _____

2

_____ ____ _____
Child's First Name **M.I.** **Last Name**

Amount you pay each month: _____

Name of person or child care center you pay: _____

3

_____ ____ _____
Child's First Name **M.I.**

Amount you pay each month: _____

Name of person or child care center you pay: _____

4

_____ ____ _____
Child's First Name **Last Name**

Amount you pay each month: _____

Name of person or child care center you pay: _____

Tell us about your health insurance.

1. **Mark one of the 5 boxes below.**
2. **Fill in the items below the box you mark.**

Health insurance means you have:

- Medicaid or Medicaid Buy-In for Children (MBIC)
- CHIP or SKIP
- Any insurance that helps pay your costs for health care

☐ **I do not have any kind of insurance.**

▶ Did you apply for Medicaid in the past 6 months or MBIC in the past 12 months?

☐ No

☐ Yes ▶ ☐ Medicaid ☐ MBIC Attach a copy of your Medicaid or MBIC letter to this application. If you do not have it yet, send us a copy as soon as you get it.

▶ Did you apply for CHIP or SKIP in the past year?

☐ No

☐ Yes ▶ Attach a copy of your CHIP or SKIP letter to this application. If you do not have it yet, send us a copy as soon as you get it.

▶ Go to page 10.

☐ **I have Medicaid. This is my Medicaid number:** _____

☐ **I have MBIC. This is my number:** _____

▶ Attach a copy of your Medicaid or MBIC card or letter.

▶ Go to page 10.

☐ **I have CHIP or SKIP.**

▶ When did it start? _____

▶ Attach a copy of both sides of your cards to this application.

If you do not have your cards, write in the names of your plans here:

_____	_____	_____
Medical	**Dental**	**Vision**

▶ Go to page 10.

☐ **I have other health insurance.**

▶ Attach a copy of both sides of your card to this application.

▶ Do you get this insurance through a job?

☐ No ▶ Answer Part 1 on page 9.

☐ Yes ▶ Answer Parts 1 **and** 2 on page 9.

LOOK! **Fill in this page only if you have health insurance.**

PART 1

What kind of insurance is it?

☐ Major Medical ☐ HMO ☐ PPO

☐ Drugs Only ☐ Dental Only ☐ Vision Only

☐ _____

How much does it cost each month? _____

LOOK! This is the amount you pay for directly or your employer takes out of your pay.

▶ Do you need help paying this amount? ☐ Yes ☐ No

If you answer yes and are not on the waiting list, we will contact you to see if we can pay this amount.

What is your deductible? _____

LOOK! A "deductible" is the money you have to pay when you go to the doctor or hospital.

Do you need help paying the co-pays for drugs?

☐ Yes ☐ No

LOOK! If you do not have a co-pay for drugs, mark the box for "no".

PART 2

Who is the person who gets the insurance at work?

_____ ____ _____
First Name **M.I.** **Last Name**

▷ What is this person's social security number? _____

▷ Who is this person's employer?

_____ ( ) _____
Name **Phone**

You need to know some things about our program. Then, you need to sign below.

1. **Read the next two pages** about your rights and duties (responsibilities) with our program.

2. **Sign below.** When you sign here, it means that you agree that:
   - You read all of pages 11 and 12.
   - You understand all that is on those pages.
   - You will follow what those pages say.
   - You understand what your rights and responsibilities are with our program.
   - You understand that “we” and “our program” mean the Children with Special Health Care Needs Services Program (or the CSHCN Services Program) of the Department of State Health Services.
   - All the things you wrote on the forms to apply for our program are true, correct, and complete.
   - You did not leave anything out.
   - You understand that if you hold back any facts or tell us something that is not true, you may be doing something that is against the law. In that case, you could lose your benefits, have to pay money back, or go to jail.
   - We and others can give out information about you to find out:
     - if you can get services, or
     - who can pay for the services you get.
   - We can release information about
     - you
     - the money you earn, or
     - the health care you get.
   - Your permission will last for **six months** from the date you sign this.

_____
Print your name here

_____ _____
Sign your name here **Date mm/dd/yy**

Notice About Your Right To Privacy

Except in some cases, you have the right to ask for and know the information the State of Texas has about you. You can ask for it at any time. You can get it and make sure it is right. You have the right to ask the state agency to correct anything that is wrong. See http://www.dshs.state.tx.us for more information on your right to privacy. (Reference: Government code, Section 552.021, 552.023, 559.003, and 559.004)

These two pages show your rights and duties. You must read and understand them.

These are your rights:

- You have the right to know all of the information that we collect about you.
- You have the right to be given this information if you ask for it.
- You have the right to review it.
- You have the right to ask us to correct any thing that is not correct.
- You understand that the website www.dshs.state.tx.us/policy/privacy.shtm will tell you how we will keep your information private.
- You have the right to be treated fairly, equally, and without regard to race, color, creed, religion, national origin, gender, age, political beliefs, or disability.
- You understand that this treatment will go along with state and federal law. If you think you have not been treated fairly and equally, you can call the Office of Civil Rights of the United States Department of Health and Human Services at 1-800-368-1019.
- You understand that what you write on the Program application will not be shared with the Internal Revenue Service (IRS) or the United States Citizenship and Immigration Services (formerly the Immigration and Naturalization Service [INS]).
- You have the right to use the appeals process when you disagree with a decision we make about you.
- You have the right to receive a timely response to your appeals.
- You have the right to two types of appeals: the **administrative review** and the **fair hearing**. (See next column).

Administrative Review

This type of appeal is a way for you to tell us the reasons why you think we should change one of our decisions about your case. You must request a review within **30** days of the date on the letter that tells you our decision. You must state in your request why you disagree with our decision. Be sure to include any items or proof that you think help to support what you state in the request.

You can ask for a review by sending a fax to (512) 776-7238, or by sending a written request to:

PHSU-CSHCN Administrative Review
Mail Code 1938
Department of State Health Services
P.O. Box 149347
Austin, Texas 78714-9347

We will send you a letter after we finish our review. The letter will tell you our decision. If you do not agree with that decision, you have a right to request a Fair Hearing.

Fair Hearing

You can request a fair hearing when you disagree with our decision from the administrative review. You must request a hearing within **20** days of the date on the letter that tells you our decision from the administrative review. If you do **not** request a hearing within the 20-day period, you will give up your right to the hearing, and our decision from the administrative review will be final.

If you request a hearing, you should state why you disagree with our decision. Be sure to include any items or proof that you think will help to support what you state in the request.

You may represent yourself or have legal counsel or another spokesperson at the hearing. You can ask for a fair hearing by sending a fax to (512) 776-7238, or by sending a written request to:

PHSU-CSHCN Fair Hearing
Mail Code 1938
Department of State Health Services
P.O. Box 149347
Austin, Texas 78714-9347

These are your duties.

Your **duties** are the things you must do as a client in our program.
We show the types of duties you have in the lists below.

1 About this application:

- You must put only true, correct, and complete information on this application.
- You must answer every question on the application.
- You must not leave out any information that the application asks for.
- You must give us any proof we ask for. We can ask you to give proof of anything that you write on the application.
- You must reapply to our program on time every six months, even if you are on the waiting list. "On time" means on or before the date when your eligibility ends.
- You must tell us about any changes in the facts about yourself within 30 days of the change. These facts include your address, phone number, income, health care coverage, and family situation. You must **not** wait until your next application to update these facts if they change.

2 About the rules of our program:

- You understand that our program rules describe **all** of your rights and duties.
- You understand that we will give you a copy of the rules if you ask for one.
- You agree to abide by all of our rules.

3 About where you live:

- You must intend to continue living in Texas.
- You must not claim to be a resident of another state or country.
- You understand that we cannot pay for services for anyone who comes to Texas just to get health care.

4 About how to get services:

- You must get services from doctors and others who are part of our program.
  - You can get services from others if you want to, but we cannot pay for those services.

5 About other insurance you may have:

- You understand that we will only pay for services you get **after** all your other insurance or health care programs have refused to pay for them.
- You understand that state law may allow your insurance benefits to be paid directly to us. In that case, the health insurance company can pay us back directly for any care we paid for.
- You understand that when you sign the Program's Client Application form, you are saying that:
  - we can collect the payments of any health insurance benefits intended for you, and
  - your insurance company can pay your health care providers directly for benefits and services you get through us.
- You agree to pay us back if you ever get money from a lawsuit that pays for services we already paid for.

6 About money you may owe us:

- You understand that if we overpay you or pay you in error, you **must** pay back any money that you owe us.
- You will pay us within a reasonable time after we tell you that you owe us money.
- You understand that we can take the amount you owe out of any money we pay in future.
- You must pay the money back even if you are no longer in our program or you leave our program.
- You or your estate will pay us any money that you owe in a single lump sum if you are no longer in our program.

LOOK!

There are 5 more pages in this booklet. Here's what you need to know about them.

- The next 2 pages (14-15) show the Texas counties and the addresses for the local program offices.
- Use those pages to find the address where you must send your complete application. (See instructions inside the front cover.)
- The Physician and Dentist Assessment Form, or PAF, starts **after** page 15.
  - The PAF is a form that your doctor or dentist **must** fill out and sign as part of your application.
  - You must send it in with your first application.
  - After you are accepted into the program, you will need to send a new PAF in every 12 months.
  - You can also send in a new doctor's form any time that your health condition changes.
- There are instructions for the PAF on the next page.
- If you or your doctor has questions, please call us at 1-800-252-8023.

Texas Counties and Local Codes

Anderson–4/5N
Andrews–9/10
Angelina–4/5N
Aransas–11C
Archer–2WF
Armstrong–1C
Atascosa–8
Austin–6/5S
Bailey–1L
Bandera–8
Bastrop–7A
Baylor–2 WF
Bee–11C
Bell–7T
Bexar–8
Blanco–7A
Borden–9/10
Bosque–7T
Bowie–4/5N
Brazoria–6/5S
Brazos–7A
Brewster–9/10
Briscoe–1L
Brooks–11C
Brown–2A
Burleson–7A
Burnet–7A
Caldwell–7A
Calhoun–8
Callahan–2A
Cameron–11H
Camp–4/5N
Carson–1C
Cass–4/5N
Castro–1L
Chambers–6/5S
Cherokee–4/5N
Childress–1L
Clay–2WF
Cochran–1L
Coke–9/10
Coleman–2A
Collin–3
Collingsworth–1C
Colorado–6/5S
Comal–8
Comanche–2A
Concho–9/10
Cooke–3
Coryell–7T
Cottle–2WF
Crane–9/10
Crockett–9/10
Crosby–1L
Culberson–9/10
Dallam–1C
Dallas–3
Dawson–9/10
Deaf Smith–1C
Delta–4/5N
Denton–3
DeWitt–8
Dickens–1L
Dimmitt–8
Donley -1C
Duval–11C
Eastland–2A
Ector–9/10
Edwards–8
Ellis–3
El Paso–9/10
Erath–3
Falls–7T
Fannin–3
Fayette–7A
Fisher–2A
Floyd–1L
Foard–2WF
Fort Bend–6/5S
Franklin–4/5N
Freestone–7T
Frio–8
Gaines–9/10
Galveston–6/5S
Garza–1L
Gillespie–8
Glasscock–9/10
Goliad–8
Gonzales–8
Gray–1C
Grayson–3
Gregg–4/5N
Grimes–7A
Guadalupe–8
Hale–1L
Hall–1L
Hamilton–7T
Hansford–1C
Hardeman–2WF
Hardin–6/5S
Harris–6/5S
Harrison–4/5N
Hartley–1C
Haskell–2 WF
Hays–7A
Hemphill–1C
Henderson–4/5N
Hidalgo–11M
Hill–7T
Hockley–1L
Hood–3
Hopkins–4/5N
Houston–4/5N
Howard–9/10
Hudspeth–9/10
Hunt–3
Hutchinson–1C
Irion–9/10
Jack–2WF
Jackson–8
Jasper–4/5N
Jeff Davis–9/10
Jefferson–6/5S
Jim Hogg–11L
Jim Wells–11C
Johnson–3
Jones–2A
Karnes–8
Kaufman–3
Kendall–8
Kenedy–11C
Kent–2A
Kerr–8
Kimble–9/10
King–1L
Kinney–8
Kleberg–11C
Knox–2WF
Lamar–4/5N
Lamb–1L
Lampasas–7T
LaSalle–8
Lavaca–8
Lee–7A
Leon–7T
Liberty–6/5S
Limestone–7T
Lipscomb–1C
Live Oak–11C
Llano–7A
Loving–9/10
Lubbock–1L
Lynn–1L
Madison–7A
Marion–4/5N
Martin–9/10
Mason–9/10
Matagorda–6/5S
Maverick–8
McCulloch–9/10
McLennan–7T
McMullen–11C
Medina–8
Menard–9/10
Midland–9/10
Milam–7T
Mills–7T
Mitchell–2A
Montague–2WF
Montgomery–6/5S
Moore–1C
Morris–4/5N
Motley–1L
Nacogdoches–4/5N
Navarro–3
Newton–4/5N
Nolan–2A
Nueces–11C
Ochiltree–1C
Oldham–1C
Orange–6/5S
Palo Pinto–3
Panola–4/5N
Parker–3
Parmer–1L
Pecos–9/10
Polk–4/5N
Potter–1C
Presidio–9/10
Rains–4/5N
Randall–1C
Reagan–9/10
Real–8
Red River–4/5N
Reeves–9/10
Refugio–11C
Roberts–1C
Robertson–7T
Rockwall–3
Runnells–2A
Rusk–4/5N
Sabine–4/5N
San Augustine–4/5N
San Jacinto–4/5N
San Patricio–11C
San Saba–7T
Schleicher–9/10
Scurry–2A
Shackleford–2A
Shelby–4/5N
Sherman–1C
Smith–4/5N
Somervell–3
Starr–11M
Stephens–2WF
Sterling–9/10
Stonewall–2A
Sutton–9/10
Swisher–1L
Tarrant–3
Taylor–2A
Terrell–9/10
Terry–1L
Throckmorton–2WF
Titus–4/5N
Tom Green–9/10
Travis–7A
Trinity–4/5N
Tyler–4/5N
Upshur–4/5N
Upton–9/10
Uvalde–8
Val Verde–8
Van Zandt–4/5N
Victoria–8
Walker–6/5S
Waller–6/5S
Ward–9/10
Washington–7A
Webb–11L
Wharton–6/5S
Wheeler–1C
Wichita–2WF
Wilbarger–2WF
Willacy–11H
Williamson–7A
Wilson–8
Winkler–9/10
Wise–2WF
Wood–4/5N
Yoakum–1L
Young–2WF
Zapata–11L
Zavala–8

Local Offices of the CSHCN Services Program

1C - Canyon Office
Health Services Region 1
PO Box 60968, WTAMU
Canyon, TX 79016-0968
Phone: 806-655-7151, ext. 1109
Fax: 806-655-0820

1L - Lubbock Office
Health Services Region 1
6302 Iola Ave.
Lubbock, TX 79424-2721
Tel.: 806-744-3577
Fax: 806-783-6455

2A - Abilene Office
Please send applications and ask questions about applying to the Wichita Falls Office.

2WF - Wichita Falls Office
Health Services Region 2
PO Box 300
Wichita Falls, TX 76307-0300
Phone: 940-689-5930
Fax: 940-689-5925

3 - Arlington Office
Health Services Region 3
1301 S. Bowen Rd., Ste. 200
Arlington, TX 76013-2262
Phone: 817-264-4619
Fax: 817-264-4911

4/5N - Tyler Office
Health Services Region 4/5N
1517 West Front St.
Tyler, TX 75702-7822
Phone: 903-533-5269
Fax: 903-595-4706

6/5S - Houston Office
Health Services Region 6
5425 Polk Ave., Ste. J
Houston, TX 77023-1497
Phone: 713-767-3111
Fax: 713-767-3125

7A - Austin Office
Health Services Region 7
1601 Rutherford Ln., Ste. C-3
Austin, TX 78754-5119
Phone: 800-789-2865
Fax: 512-873-6345

7T - Temple Office
Health Services Region 7
2408 S. 37th St.
Temple, TX 76504-7168
Phone: 1-800-789-2865
Fax: 254-773-2722

8 - San Antonio Office
Health Services Region 8
7430 Louis Pasteur Dr.
San Antonio, TX 78229-4507
Phone: 210-949-2155
Fax: 210-949-2047

9/10 - El Paso Office
Health Services Region 9/10
401 East Franklin, Ste. 210
El Paso, TX 79901-1206
Phone: 915-834-7682
Fax: 915-834-7804

11H - Harlingen Office
Health Services Region 11
601 West Sesame Dr.
Harlingen, TX 78550-4040
Phone: 956-444-3231
Fax: 956-444-3293

11C - Corpus Christi Office
Health Services Region 11
5155 Flynn Pkwy.
Corpus Christi, TX 78411
Phone: 361-660-2263
Fax: 361-668-4000

11L - Laredo Office
Health Services Region 11
1500 Arkansas Ave., Ste. 3
Laredo, TX 78043-3049
Phone: 956-794-6385
Fax: 956-729-8600

11M - McAllen Office
Health Services Region 11
4501 W. Business Hwy. 83
McAllen, TX 78501-9907
Phone: 956-971-1363
Fax: 956-971-1275

CSHCN Services Program Physician/Dentist Assessment Form Instructions

Instrucciones para el Formulario de Evaluación del Médico / Dentista

(For Application to CSHCN Services Program / Parte de la solicitud al Programa de Servicios CSHCN)

Thank you for helping this family to apply for benefits from the Children with Special Health Care Needs (CSHCN) Services Program. The Physician/Dentist Assessment Form (PAF) is a key part of the application process. The PAF is a two-page form with a block that identifies the applicant, followed by six other short sections that you need to complete about the applicant. Section 7 is for information about you. Please fill in the applicant's identifying information and then go on to section 1.

1) DIAGNOSIS AND EVALUATION SERVICES (screening exam):

If further examinations or tests are not needed, please check the "No" box. Do not leave this section blank. It will slow the application approval process.

If you need to do further examinations or tests to determine if the applicant meets the CSHCN Services Program's "medical certification definition" (see section 2), you must check the "Yes" box and complete **all** of section 1.

Please note that whenever the CSHCN Services Program has a waiting list, the Program cannot pay for diagnosis and evaluation services for new applicants. To find out if the Program currently has a waiting list, call 1-800-252-8023.

2) MEDICAL CERTIFICATION DEFINITION AND DIAGNOSES:

Please pay particular attention to this section. It contains the Program's definition of a child with special health care needs. You must certify whether the applicant does or does not meet either definition A or B.

The primary diagnosis must be a chronic illness or disability with a physical manifestation that affects the applicant and also meets the Program's definition. The form has spaces to add as many as three additional diagnoses.

Please ensure that the primary diagnosis is completed to the highest level of specificity (4 or 5 digits). Forms that are not filled out to their highest level will not be accepted by the CSHCN Services Program.

3) QUESTIONS FOR INITIAL APPLICATION TO THE CSHCN SERVICES PROGRAM:

Complete section 3 only if this is the first time the applicant has ever applied to the CSHCN Services Program.

4) DETERMINATION OF URGENT NEED FOR SERVICES:

This section is **very important**, especially when the CSHCN Services Program has a waiting list. Complete this section thoroughly. It has three parts.

Your answers to section 4 help the Program's physicians determine which children need health care services most urgently. This information is a factor in determining the order in which to remove clients from the waiting list whenever available funds make it possible to do so.

If you answer "Yes" to 4A or 4B, you must provide an explanation. Use the space on the form or attach additional sheets if needed.

When answering 4A, please base your answer on what would happen if the applicant had no resources to pay for health care.

5) FUNCTIONAL NEEDS:

The Texas Legislature requires the CSHCN Services Program to collect this information. Please check **all** appropriate boxes.

6) SERVICES NEEDED:

Please talk with the family and then check the blocks for any and all services the applicant may require. This information will help the CSHCN Services Program plan for effective services now and in the future. It will not affect the applicant's eligibility for services.

7) PHYSICIAN/DENTIST DATA:

Section 7 requires the signature of the physician or dentist AND must be filled out completely. In order to process the application, the doctor (M.D., D.O., D.D.S., or D.M.D.) must sign and date the form. It cannot be signed by a nurse or physician's assistant. The Program must also have your Provider ID number. Phone numbers are especially important.

Thank you again for all you do to help the clients and families of the CSHCN Services Program!

Revised 04/08

CSHCN Services Program Physician/Dentist Assessment Form

Formulario de Evaluación del Médico / Dentista

(For Application to CSHCN Services Program / Parte de la solicitud al Programa de Servicios de CSHCN)

Please complete and sign this form for the person applying for the Children with Special Health Care Needs (CSHCN) Services Program. The same form can be used for new and renewal applicants. If you need more copies or have questions, please refer to the instruction sheet or call 1-800-252-8023. Give the completed form to the parent or guardian, or send it to the applicant's local CSHCN Services Program office. *Only providers enrolled in the CSHCN Services Program may be reimbursed for diagnosis and evaluation services.*

NOTICE ABOUT YOUR RIGHT TO PRIVACY
Except in some cases, you have the right to ask for and know the information the State of Texas has about you. You can ask for it at any time. You can get it and make sure it is right. You have the right to ask the state agency to correct anything that is wrong. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

AVISO SOBRE SU DERECHO A LA PRIVACIDAD
Salvo en algunos casos, usted tiene el derecho a pedir y conocer la información que el Estado de Texas tiene con respecto a usted. Usted puede pedirla en cualquier momento. Puede obtenerla y asegurar que es correcta. Tiene el derecho a pedir que el organismo estatal corrija todo lo que sea incorrecto. (Referencia: Código gubernamental, Secciones 552.021, 552.023, 559.003 y 559.004)

Applicant's Name (Last, First, Middle) _____ **Client No.** (if known) _____ **Date of Birth** (mm/dd/yyyy) _____

Address (Street, City, State, Zip) _____

Parent / Guardian Name _____ **Telephone** (_____) _____

1) Diagnosis and Evaluation Services (screening exam):

Is this a request for coverage of services to determine whether the applicant has a chronic physical or developmental condition? If so, please indicate the appropriate V-Code and proceed to Physician/Dentist Data (Section 7). ☐ **Yes** ☐ **No**

_____ *(V-code)*

If not, continue with rest of form.

2) Medical Certification Definition and Diagnoses:

The applicant must meet either definition A or B listed below:

A) A person younger than 21 years of age who has a chronic physical or developmental condition that:
- Will last or is expected to last for at least 12 months AND
- Results in, or if not treated, may result in limits to one or more major life activities AND
- Requires health and related services of a type or amount beyond those required by children generally AND
- Has a physical (body, bodily tissue, or organ) manifestation AND
- May exist with accompanying developmental, mental, behavioral, or emotional conditions BUT <u>is not solely</u> a delay in intellectual development or solely a mental, behavioral, or emotional condition.

B) A person of any age who has cystic fibrosis.

I CERTIFY THAT THE APPLICANT MEETS THE ABOVE DEFINITION. ☐ **Yes** ☐ **No**

PRIMARY DIAGNOSIS: *(condition must meet definition A or B above <u>and, thus, must have a physical manifestation</u>)*

ICD-9-CM Code *(required)*: _____ **Descriptor** *(required)*: _____

(ICD-9-CM codes *<u>must be at the highest level of specificity</u>* (4 or 5 digits). A 3-digit code is used only when there are no 4-or 5-digit codes within that category)

<u>OTHER SECONDARY DIAGNOSES:</u>

ICD-9-CM Code: _____ **Descriptor:** _____

ICD-9-CM Code: _____ **Descriptor:** _____

ICD-9-CM Code: _____ **Descriptor:** _____

3) Questions for Initial Application to the CSHCN Services Program:

(if this is a renewal application, proceed to step 4)

Is applicant's condition a result of a traumatic injury or accident: ☐ **Yes** ☐ **No**

Date of trauma or accident (mm/dd/yyyy): _____

Date of discharge if hospitalized (mm/dd/yyyy): _____

Date of admission to rehab facility (mm/dd/yyyy): _____

Is applicant younger than one year of age: ☐ **Yes** ☐ **No**

Was the applicant born before 36 weeks gestation? ☐ **Yes** ☐ **No**

If yes, date of discharge after birth (mm/dd/yyyy): _____

Has the applicant spent 14 consecutive days out of the hospital? ☐ **Yes** ☐ **No**

Go to Page 2 / Vaya a la página 2

form is incomplete without both pages completed

el formulario está incompleto si las dos páginas no están rellenadas

THIS IS A TWO-PAGE FORM THAT REQUIRES THE SIGNATURE OF A MD, DO, DDS, OR DMD ON PAGE 2. FORMS WITHOUT THIS SIGNATURE ARE INCOMPLETE AND WILL BE RETURNED.

CSHCN Services Program Physician/Dentist Assessment Form *(page 2)*

Formulario de Evaluación del Médico / Dentista (página 2)

Applicant's Name: _____ *Client #:* _____ *DOB:* _____
(Last, First, Middle) *(if known)* *(mm/dd/yyyy)*

4) DETERMINATION OF URGENT NEED FOR SERVICES:

A) Would an inability to get healthcare services cause a permanent increase in disability, intense pain or suffering, or death? Please base your answer on what would happen if the applicant had no resources to pay for health care.

☐ *Yes. If yes, explanation required (use space provided or attach narrative):*

☐ *No. If no, continue with rest of form.*

B) Is the applicant actively planning to live in a nursing home, group home, or similar institution in the next six months?

☐ *Yes. If yes, explanation required (use space provided or attach narrative):*

☐ *No. If no, continue with rest of form.*

C) Please indicate any additional information related to the complexity or severity of applicant's condition or need for care that the CSHCN Services Program should know below or with attached narrative.

5) FUNCTIONAL NEEDS

Check appropriate blocks indicating the applicant's functional needs or limitations:

☐ Physical ☐ Developmental ☐ Behavioral ☐ Emotional

6) SERVICES NEEDED

Check the blocks for services the applicant may require.
(Data is for CSHCN Services Program planning purposes and does not affect eligibility.)

- ☐ stem cell transplant
- ☐ case management
- ☐ dental services
- ☐ drugs
- ☐ durable medical equipment
- ☐ expendable medical supplies
- ☐ family support services
- ☐ growth hormone
- ☐ help with drug co-payments
- ☐ hemophilia blood factor products
- ☐ home health or nursing services
- ☐ inhaled tobramycin
- ☐ inpatient hospital
- ☐ Insurance Premium Payment Assistance
- ☐ mental health services
- ☐ outpatient services *(including PT, OT, & SLP)*
- ☐ physician services
- ☐ pulmozyme
- ☐ renal dialysis or transplant
- ☐ total parenteral nutrition
- ☐ transportation *(including meals and lodging)*
- ☐ vision services
- ☐ other: _____

7) PHYSICIAN / DENTIST DATA

Physician/Dentist's Name (type or print) _____ *Provider Identifier #* _____ *Tax ID #* _____ *Specialty* _____

Mailing Address (Street, City, State, and Zip Code) _____

Contact Person's Name (type or print) _____ *Phone* ( ) _____ *Fax* ( ) _____

PHYSICIAN/DENTIST SIGNATURE _____ DATE _____
*(**MUST BE** signed by M.D., D.O., D.D.S., or D.M.D.)*

THIS IS A TWO-PAGE FORM THAT REQUIRES THE SIGNATURE OF A MD, DO, DDS, OR DMD ON PAGE 2. FORMS WITHOUT THIS SIGNATURE ARE INCOMPLETE AND WILL BE RETURNED.