Children's Special Health Care Services (CSHCS) Enrollment Packet Instructions

Children's Special Health Care Services consists of twelve (12) pages. Please print all information except where signatures are required. The program serves Indiana residents age 0-21 years of age. Applicants with Cystic Fibrosis can apply for the program at any age, but must meet the financial guideline and be financially eligible.

Remember the application date must be on all pages where a date is required. Exception – page twelve (12) should be the current date because this form is only good for sixty (60) days. **The completed enrollment packet must be submitted to CSHCS within thirty (30) days of the application date. The effective date of coverage will be determined based on the date the application is received by the program for processing.**

Enrollment Checklist. This checklist will help to ensure that you are submitting all necessary documents. **If you are sending this application for a diagnostic, the family must be financially eligible for CSHCS and must be testing for an eligible medical condition.** If the family refuses to cooperate or does not return requested documentation, application is to be submitted for denial and appropriate reason checked.

Page 1: Applicant and parent/guardian information. The Application Date is the date you are completing the form. The CSHCS Key Number and Effective Date will be completed by CSHCS 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 or state, the caseworker's information goes on the first line for parent/guardian. The foster parents can sign the application on the second line;
b) A surrogate parent, first steps coordinator, step-parent or foster parent who has not legally adopted the applicant, cannot sign this application.

We must know the medical condition for which an applicant is applying to CSHCS. This can be exactly what the doctor has told you and/or the parent. If this application is being completed by someone other than the parent, please sign and complete the requested information.

Page 2: Household Members and Income Information. List all persons living in the household **regardless if related or not** (example: Mom, child & mom's boyfriend). We will count the boyfriend's or any other working household member's income. A pregnant woman is considered one (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, o-other, b=bother, a=applicant, s=self, etc. for other insurance put y=yes or n=no. There are some exceptions, so if you have an unusual situation please contact CSHCS at **1-800-475-1355, option 2**.

The CSHCS program counts **ALL** income for the household and we use **Gross income**. The CSHCS program requires that income documentation be submitted with the application and the preferred documentation is **check stubs from the three (3) most recent consecutive pay periods.** If the family is self-employed, receives farm income, or additional income that does not reflect on check stubs, provide the latest Federal 1040 tax return, including Schedule 1. If parent/guardian/applicant

states they have no income, request written and signed statements on how rent, food, and utilities are paid and list the dollar amount spent on each. If this application is being completed by someone other than the parent/guardian/applicant, please sign the bottom of the income page; otherwise, CSHCS personnel sign this page.

Page 3: Medical Insurance Information. Complete boxes 1 and 2 always. Boxes 3-7 should be completed only if there is private insurance.

Page 4: Provider History Information. Complete this section as thorough as possible.

Page 5: Medicines and Medical Equipment. Complete this section as thorough as possible.

Page 6: Application for Enrollment form. Read, sign and date.

Page 7: Authorization for the collection of Information. Read, Sign and date.

Page 8: Authorization for the Release of Protected Health Information. This form allows CSHCS to exchange information with person/entity helping parent/guardian/applicant complete the application. **If no one is helping parent/guardian/applicant complete this application, the form does not need to be filled out**.

Page 10: Authorization to Release and Share Medical Information. REMEMBER: **Put the current date** on this form. Complete one for each provider that can verify medical diagnoses. If the medical is less than one (1) year old and can be submitted with the application, there is no need to send this form to any provider. 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 12: 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 can verify medical diagnoses. If the medical is being submitted with the application there is no need to mail the form however; it should be sent with the application.

All applicants applying for CSHCS must apply for Indiana Medicaid and contact CSHCS with confirmation you have applied. (e.g. confirmation number from applying on-line, recent approval or denial letter).If applicant is age nineteen (19) or older, they must apply for the most appropriate Medicaid program and supply proof of submitted application and completion of eligibility process.

Other required documentation that must be submitted with application include: Copy of applicants birth certificate, copy of any insurance cards (front and back) for applicant. Proof of Indiana residency (e.g. rent/mortgage receipt or utility bill).

NOTE: If you have questions, please call 1-800 475-1355, Option 2, Monday thru Friday, 8:15am – 4:45pm. You may fax the application to (317)-233-1342 or mail to Children's Special Health Care Services, 2 N. Meridian St. 5C, Indianapolis, IN 46204.