



## CSHCS ENROLLMENT PACKET

Test

Indiana State Department of Health  
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.*

Children's Special Health Care Services Enrollment Packet consists of 15 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 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 the 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 a diagnostic, the family must be financially eligible for CSHCS and must be testing for an eligible medical condition.** If family refuses to cooperate or does not return requested documentation, application is to be submitted for denial and appropriate reason checked.

**Page 4: Applicant and parent/guardian information.** The **Application Date** is the date you are completing the form. 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), a step-parent who has not legally adopted the applicant, or a Foster Parent can not sign this application.

***We need to 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 5: Household Members and Income Information.** List all persons living in the household **regardless if related or not** (i.e. mom, child & mom's boyfriend). We will count the boyfriend's or any other working household member'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, o=other, b=brother, a=applicant, etc. There are some exceptions, so if you have an unusual situation, please call, as they are too numerous to list. Complete information across the table and for Other Insurance, put Y or N.

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 latest Federal 1040 that was filed. If parent/guardian/applicant states they have no income, ask, document and request written and signed statements on how rent is paid, food is bought, and utilities are paid. If this application is being completed by someone other than the parent/guardian/applicant, please sign the bottom of Income page; otherwise, CSHCS personnel will sign this page.

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

**Page 7: Provider History Information.** Complete as thoroughly as possible.

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

**Page 9: Application for Enrollment form.** Read, sign, and date.

**Page 10: Authorization for the Collection of Information.** Read, sign, and date.

**Page 11: 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 13: Authorization to Release and Share Medical Information.** REMEMBER: put **current date** on this form. Complete one for each provider that can verify medical diagnoses. *If the medical is less than 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 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 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.

**Additional Forms: Hoosier Healthwise/Medicaid: If the applicant is not on Hoosier Healthwise/Medicaid, this form needs to be completed. The parent/guardian or applicant can call 1-800-403-0864, option 2 for instructions on where to mail this form. Please copy the HHW form and submit the copy 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 the Training Coordinator. The direct number is 317-233-5571.**

**ENROLLMENT CHECKLIST**

Test

Applicant's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

\_\_\_\_\_ **APPLICATION IS FOR DIAGNOSTICS TESTING (applicant is financial eligible for CSHCS and the test is for an eligible medical condition)**

\_\_\_\_\_ Income page signed, income documentation attached

\_\_\_\_\_ Hoosier HealthWise/Medicaid: Submit documentation that applicant either has HHW or has applied. **(THIS IS A MANDATORY REQUIREMENT OF THE CSHCS PROGRAM). The CSHCS application may be submitted while applicant is awaiting a HHW decision.**

\_\_\_\_\_ Medical Insurance Information page completed (if applicable), signed and dated, copy of either HHW card or insurance card (front & back) attached

\_\_\_\_\_ Authorization for the Collection of Information form signed and dated

\_\_\_\_\_ Authorization for the Release of Protected Health Information form signed and dated (if applicable)

\_\_\_\_\_ Application for Enrollment with CSHCS page signed and dated

\_\_\_\_\_ Copy(ies) of Authorization to Release & Share Medical information completed, signed and dated attached **(original(s) are 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 application may be submitted while applicant is awaiting a HHW decision.**



# HOUSEHOLD MEMBERS and INCOME INFORMATION

Test

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

Name	Relationship to applicant	DOB	Gender	Race	Ethnicity	SSN#	Date applied for HHW or Medicaid	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	
<b>NAME OF PERSON RECEIVING INCOME →→→→→</b> <b>Use additional paper if necessary</b>						
	Gross Amount	How Often	Gross Amount	How Often	Gross Amount	How Often
Wages/Fees/Commissions/Tips/Sick Benefits						
Social Security or SSD or SSI (SSI <b>NOT</b> 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) \_\_\_\_\_

\_\_\_\_\_

**CSHCS USE ONLY: Total Household Income \$** \_\_\_\_\_

Date: \_\_\_\_\_

(Signature of Agency or CSHCS Personnel)

# MEDICAL INSURANCE INFORMATION

Complete a new form for each insurance coverage.

<b>1. APPLICANT IDENTIFYING INFORMATION:</b> Name: _____ D.O.B.: _____ CSHCS #: _____ Address: _____ IN _____ Street City ZIP Code	
<b>2. HOOSIER HEALTHWISE or MEDICAID (age appropriate) NUMBER:</b> Complete One: Current Coverage Effective Date: _____ Pending HHW Date/or Date application was mailed: _____ Not Financially Eligible Date of Denial: _____ Medicaid Disability with/without spend down \$ _____ (if known)	
<b>3. POLICYHOLDER INFORMATION:</b> Name: _____ Relationship: _____ Telephone: ( ) _____ Address: _____ Street City State ZIP Code	
<b>4. INSURANCE COMPANY INFORMATION:</b> <input type="checkbox"/> Primary <input type="checkbox"/> 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	
<b>5. POLICY NUMBER:</b> _____ Member/I.D. #: _____ Group/Acct. #: _____ Effective date dependent will be covered under policy: _____ Termination Date: _____	
<b>6. EMPLOYER INFORMATION:</b> Name of Employer: _____ Address: _____ Street City State ZIP Code Telephone: ( ) _____ Start Date: _____	
<b>7. COVERAGE INFORMATION:</b> Check As Applicable: A. Second Insurance Company Coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO B. Therapy Services Covered: <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech C. Co-Payments? <input type="checkbox"/> YES <input type="checkbox"/> NO Office Visit Amt: \$ _____ Specialist Amt: \$ _____ Emergency Room Amt: \$ _____ Other Amt: \$ _____ Prescriptions Amt: \$ _____ DME Services Amt: \$ _____ D. Deductibles? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, Amt: \$ _____ E. Maximum Out of Pocket Expense \$ _____	F. Is there a pre-existing clause? <input type="checkbox"/> YES <input type="checkbox"/> NO Effective Date: _____ G. Is there a dental plan? <input type="checkbox"/> YES <input type="checkbox"/> NO Name of plan if different: _____ Effec. Date: _____ Term. Date: _____ H. Lifetime maximum? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ _____ per person \$ _____ per family I. Conditions/Exclusions: _____

# PROVIDER HISTORY INFORMATION

Test

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.

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



# Application for Enrollment Children's Special Health Care Services (CSHCS)

Test

## INSTRUCTIONS FOR COMPLETING THIS FORM:

1. Applicant/Parent/Guardian must sign all copies in ink.
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. Send application to CSHCS at the address listed on the Check List Page 3.

## 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 18 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, under penalty of perjury, that all of the information, including the verified income is complete and correct to the best of my knowledge.

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 Health 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).

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

\_\_\_\_\_  
Signature of Applicant/Parent/Legal Guardian

\_\_\_\_\_  
Relationship to Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant/Parent/Legal Guardian

\_\_\_\_\_  
Relationship to Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Agency Personnel

\_\_\_\_\_  
Date

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

Test

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 re-disclosure by the recipient as required by applicable law and the privacy of my Protected Health Information may no longer be protected by HIPAA.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Agency 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 <i>(include area code)</i>	
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 <i>(include area code)</i>
Street Address		City, State and Zip Code
Entity authorized to receive confidential information		Daytime Telephone Number <i>(include area code)</i>
Street Address		City, State and Zip Code
Entity authorized to receive confidential information		Daytime Telephone Number <i>(include area code)</i>
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:	
<input type="checkbox"/> Natural or Adoptive Parent of Unemancipated Minor Child	
<input type="checkbox"/> 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**

Test

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:

\_\_\_\_\_  
Applicant/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:

\_\_\_\_\_  
Applicant'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 (Applicant if over 18 years of age)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Parent/Legal Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Agency Personnel

\_\_\_\_\_  
Date

- OVER -

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

Test

*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 Health 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 Health 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

Test

*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

Applicant'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: \_\_\_\_\_  
 \_\_\_\_\_

Immunization Information: DPT/DTaP \_\_\_\_\_ DT \_\_\_\_\_ TB \_\_\_\_\_ Varicella \_\_\_\_\_  
 \_\_\_\_\_  
 IPV/OPV \_\_\_\_\_ MMR \_\_\_\_\_ or Measles \_\_\_\_\_ Mumps \_\_\_\_\_  
 \_\_\_\_\_  
 Hep B \_\_\_\_\_ Hib \_\_\_\_\_ Rubella \_\_\_\_\_  
 \_\_\_\_\_

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**

Dear Parent/Guardian/Applicant:

Please be aware that it is a requirement of the CSHCS program that the applicant (if not already enrolled) must apply for either Hoosier Healthwise or Medicaid Disability (for those over age 19). The applicant does not have to be accepted on HHW/Medicaid, but must apply and follow-up with any appointments. Failure to complete this step will cause the CSHCS application to be denied. The acceptance or the denial letter to should be sent to CSHCS.

The items listed below should be mailed with your completed application:

- Copy of applicant's birth certificate
- Copy of any insurance information for applicant
- Copy of your last Federal Tax Form (1040), 1st page only
- If you do not file Federal Taxes, but have a W2, send it **plus** your last 3 consecutive pay stubs.
- If you do not work, please send information on how you pay your bills and buy food.
- Copy of any other income that you receive (child support, TANF, Social Security, SSI)
- Copy of proof that you live in the county (rent/mortgage receipt or utility bill, copy of driver's license)

Pages 7 & 8 of the application are very important and should be completed as fully as possible.

**On the Authorization to Release and Share Medical Information form,  
please put the actual date that you are completing this form.**

If you have any questions or concerns, please feel free to call the CSHCS program at 1-800-475-1355, Eligibility Option 2, Monday thru Friday, 8 a.m. – 4 p.m. and ask for the Training Coordinator.

Sincerely,

CSHCS Program,  
Training Coordinator

Enclosures



# 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? <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly	How often paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly
<input type="checkbox"/> Twice a month <input type="checkbox"/> Other Hours worked a week: _____	<input type="checkbox"/> Twice a month <input type="checkbox"/> Other Hours worked a week: _____
Do hours vary? <input type="checkbox"/> Yes <input type="checkbox"/> No Is person self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do hours vary? <input type="checkbox"/> Yes <input type="checkbox"/> No Is person self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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                 | 6. Military Allotment                 | 11. Interest Payments                  |
| 2. Social Security     | 7. Unemployment                       | 12. Educational Income                 |
| 3. Veteran's Benefits  | 8. Support (alimony or child support) | 13. Cash from Friends, Relatives, etc. |
| 4. Railroad Retirement | 9. Sick Benefits                      | 14. Worker's Compensation              |
| 5. Pension             | 10. Strike Benefits                   | 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.*