

## Children's Special Health Services (CSHS) Application

Families requesting financial help for special medical care from Children's Special Health Services (CSHS) must complete both sides of this application. This information will be used to determine eligibility and allow release of information to appropriate caregivers. It will be kept strictly confidential. Please provide all the requested information.

**IN ORDER TO COMPLETE YOUR APPLICATION IN A TIMELY MANNER, PLEASE SUBMIT THE FOLLOWING:**

- 1) Copies of two months current paycheck stubs of all persons living in the household for income verification.
- 2) If self-employed attach a copy of your current year 1040 tax form and profit and loss schedule, (if income shows on line 7 of 1040 we need verification).
- 3) Current physician notes regarding medical condition.
- 4) Signed and completed application.
- 5) If requesting coverage for medication, please provide name of pharmacy \_\_\_\_\_

**Patient's Name** \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Social Security No. \_\_\_\_\_ Gender \_\_\_\_\_ Race \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Message Phone \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ County of Residence \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 E-mail Address \_\_\_\_\_

**Applicant's Medical Concern(s)** \_\_\_\_\_

**Physician** \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Specialist** \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Dentist** \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Orthodontist** \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Father** \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Address if different than above \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Father's Employer** \_\_\_\_\_ Work Number \_\_\_\_\_

**Mother** \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Address if different than above \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Mother's Employer** \_\_\_\_\_ Work Number \_\_\_\_\_

**Legal Guardian if different than above** \_\_\_\_\_  
 Address \_\_\_\_\_ Phone Number \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please list the names and dates of birth of all persons living in the home ↓

NAME	Date of Birth	NAME	Date of Birth

**Release of Information:**

I certify that the information I have given is true to the best of my knowledge. I give permission to the State of Montana to make any necessary contacts to check my statements. I agree all providers can release any medical, social and insurance information about my child to CSHS upon request in order to administer CSHS benefits. Once information is provided to CSHS, I hold the provider harmless for subsequent disclosures of this information by CSHS. If I knowingly give false information to enroll my child in CSHS, I understand that I must reimburse the State of Montana for any costs incurred, and benefits from CSHS will terminate. This release is effective for 18 months from date signed.

**Revocation Statement:** I understand I have the right to revoke the above authorization for the release of information at any time by contacting CSHS in writing. Children's Special Health Services, PO Box 202951, Helena MT 59620.

\_\_\_\_\_  
**Signature (Parent or Legal Guardian)**

\_\_\_\_\_  
**Date**



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List income from all sources. Income includes but is not limited to wages, tips, social security income, unemployment income, retirement income, AFDC, child support payments received, alimony, strike benefits, interest and dividends, disability benefits, workers' compensation, veteran's payments, and Bureau of Indian Affairs payments. If there is no family income, write "NONE" and initial. Indicate how often you receive the amounts listed.

**NOTE:** Attach a copy of wage check stubs or other financial documentation to verify your claim. If self-employed, report business income from your most recent income tax return, profit and loss schedule and send a copy. **ALL REPORTED INCOME MUST BE DOCUMENTED** or your application process will be delayed.

**Gross income means before any deductions on income taxes, social security, insurance premiums, etc.**

Employee	List all Sources of Income For Household	Wages Every Two Weeks	Wages Twice Monthly	Wages Monthly	Total Gross Yearly Income

Is the child you are applying for a U.S. citizen?  Yes  No

**Do you pay for child, disabled or elderly adult care while you and your spouse are working? Supply verification.**

Person(s) receiving care	Name of person giving care	Amount paid	How often do you pay

Have you applied for **Medicaid** for this child?  Yes  No If Yes, Pending (date filed) \_\_\_\_\_

If the child has Medicaid, list card number here: \_\_\_\_\_

Medicaid Eligibility dates: *From* \_\_\_\_\_ *To* \_\_\_\_\_

**If the child has been denied Medicaid, please attach a copy of the Medicaid Denial**

**HEALTH INSURANCE INFORMATION: Please attach a copy of your insurance card(s).**

Does your family have Health Insurance?  Yes  No \_\_\_\_\_

**SUBSCRIBER – CARD HOLDER INFORMATION:**

Subscriber (Name) \_\_\_\_\_ Subscriber (Date of Birth) \_\_\_\_\_

Subscriber (Social Security Number) \_\_\_\_\_

Subscriber (Employer) \_\_\_\_\_ City/State Employed In \_\_\_\_\_

**INSURANCE COMPANY INFORMATION:**

Insurance Company (Name) \_\_\_\_\_

Address where claims are sent \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company (Phone Number) \_\_\_\_\_

Policy Number on Card \_\_\_\_\_ Eligibility Start Date \_\_\_\_\_

Group Number on Card \_\_\_\_\_ Eligibility End Date \_\_\_\_\_

Your Yearly Deductible? \_\_\_\_\_ Copay? \_\_\_\_\_

Your out of pocket monthly Health Insurance cost? \_\_\_\_\_ Maximum out of pocket (stop loss)? \_\_\_\_\_

Is the patient's condition covered by insurance?  Yes  No \_\_\_\_\_

If No, what condition(s) are not covered? \_\_\_\_\_

Does your insurance cover Prescriptions?  Yes  No \_\_\_\_\_

**DENTAL INSURANCE:**

Does your child have Dental Insurance?  Yes  No \_\_\_\_\_

Does your insurance cover Orthodontics for your child?  Yes  No \_\_\_\_\_

The Department of Public Health and Human Services (DPHHS) does not discriminate on the basis of race, color, religion, creed, political ideas, sex, age, marital status, physical or mental disability, or national origin. If you believe you have been subjected to discrimination, contact the DPHHS Human Resources Division at 406.444.3136 or the Montana Human Rights Bureau at 800.542.0807, or relay service at 711.

**RETURN THIS APPLICATION TO:**

Children's Special Health Services, PO Box 202951, Helena MT 59620-2951  
 (406) 444-3622 (local) or (800) 762-9891 (in state)  
 Fax: (406) 444-2750



Please fill this page out if you have additional Health Dental Insurance or Comments

**HEALTH INSURANCE INFORMATION: Please attach a copy of your insurance card(s).**

Does your family have Health Insurance?  Yes  No \_\_\_\_\_

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