Financial Assistance Application

Phone: 1-800-762-9891

Fax: 406-444-2750

Email: CSHS@mt.gov

Please submit your application by fax or email. Please contact Children's Special Health Services if you need to mail your application, need assistance accessing or submitting the document, or need an enlarged copy for accessibility purposes.

Children's Special Health Services can provide up to $2,000 per year of financial assistance for treatment and enabling services and/or items for qualifying children and youth with special healthcare needs (CYSHCN). A child or youth with special health care needs is defined as:

- Under the age of 22 **and,**
- Has or is at increased risk for a chronic physical, developmental, behavioral, or emotional condition **and,**
- Requires health and related services of a type or amount beyond that required by children generally.

CSHS Financial Assistance funding is limited. The purpose of the CSHS Financial Assistance program is to help meet a child or youth's needs related to diagnosis. Funds will not be used for items one would typically purchase for a child, but rather items and services that specifically support progress and improved health, safety, and well-being. Applications must meet the following requirements at a minimum:

- A medical professional must recommend treatment or an enabling service. Medical professionals are healthcare professionals certified or licensed by the appropriate Montana authority; and,
- Treatment and enabling services must be evidence-based; and,
- All other funding sources must be exhausted; and,
- Household income must be equal to or less than 300% of FPL. Eligibility for 2024 can be checked through the table titled "2024 Poverty Guidelines" on the CSHS Financial Assistance website linked here: CSHS Financial Assistance (mt.gov)

Please Note: Services rendered 12 months prior to the date of this application will not be considered. Completed applications will be processed and reviewed within 30 days of receiving. Applicants and their guardians will be notified of approval or denial as soon as possible. If the application is denied, you will receive a denial letter explaining the reason for the denial. If the application is approved, you will receive an approval letter from CSHS. Items will need to be purchased within three months of the date on the approval letter. Invoices for

services will be approved in the six months; families will need to resubmit insurance and financial information, and it will not be reconsidered for eligibility.

Please complete and sign this application and provide the following documentation:

1. The most recent tax returns for each person in the household who earns income (not required of those in the household if they are under the age of 19 and attending school)
2. A copy of the child's insurance card (front and back, must be readable)
3. Documentation of the other resources that have been used and/or applied for to support the cost of the assistance being requested financially.

Application must be signed by a medical provider and the parent/guardian to be valid. If the application is incomplete or unreadable, we will not be able to process the application until corrections are made. Please ensure all sections of the application are filled out completely and are readable before submitting.

*__Case by case exceptions will be granted by the Financial Assistance Committee__

SECTION 1: Applicant & Household Information

This section must be completed entirely, or the application will not be processed. The applicant is the Child or Youth with Special Health Care Needs (CYSHCN).

Applicant's Name: _____ DOB: _____

Main Phone: _____ Alternate Phone: _____

Email Address (for correspondence): _____

Mailing Address (for correspondence): _____

City: _____ State: _____ Zip Code: _____

Applicant's Gender:

☐ Male ☐ Female ☐ Other

Applicant's Ethnicity (Select all that apply):

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Hispanic or Latino

☐ Native Hawaiian or Pacific Islander

☐ White

☐ Middle Eastern or North African

Parent or Caregiver Name: _____

Parent or Caregiver Name: _____

Does the applicant have insurance?

Yes ☐ No ☐

Please select the type of insurance:

☐ Medicaid (Healthy Montana Kids Plus) ☐ Healthy Montana Kids CHIP

☐ Waiver Services ☐ Private Insurance

Yes. Please give the insurance information below and include a copy of the front and back of the insurance card.

Insurance Company Name, Address, and Phone Number: _____

Insurance Policy Number or Medicaid ID Number:_____

Secondary Insurance Company Name, Address, and Phone Number: _____

_____

Secondary Insurance Policy Number or Medicaid ID Number: _____

_____

Does the application have a primary care physician?

☐ No

☐ Yes. Primary Care Physician Name, Address, and Phone Number: _____

_____

Please indicate how many individuals:

Live in the applicant's primary household: _____

Earn Income in the applicant's primary household (do not count if under 19 and attending school): _____

Receive Dependent Care Services so the child's guardian can work, look for work, or attend school. (Example: Daycare, preschools, babysitter, etc.):_____

_____

SECTION 2: Financial Resources Information:

The Financial Assistance Program should only be accessed after exhausting other options, including insurance and Medicaid. If you need ideas for other financial resources, please contact CSHS.

Was this submitted to insurance?

☐ No. Please explain why if you have not.

_____

☐ Yes. Please submit the denial letter or EOB from your insurance (including Medicaid). If your insurance will not give you a denial letter, please call CSHS for assistance.

Please list any financial resources that have been applied for and/or used. If you have received assistance from other funds, please indicate which items and approximately how much was paid.

☐ I haven't tried any. Please explain.

Please list the resources that have been applied for, which items were covered, which items were not covered, and the amount covered. If applicable.

Would you be interested in learning about other financial or support resources?

☐ No

☐ Yes. Please sign below to allow us to refer you to other services.

Parent or Legal Guardian Signature Date

Release of Information: I verify that the information I have given is true to the best of my knowledge. I permit the State of Montana to make any necessary contract to check my statements. I agree that all providers can release any medical, social, and insurance information about my child to CSHS upon request 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 the date signed.

Withdrawal Statement: I understand I have the right to withdraw or cancel the above authorization for the release of information at any time by contacting CSHS. Children's Special Health Services, PO Box 4210, Helena, MT 59620, 1800-7620-9891.

Parent or Legal Guardian Signature Date

FAMILIES: PLEASE SEE INSTRUCTIONS BELOW FOR SECTIONS 3 AND 4

- **Section 3: Must be filled out completely, signed, and dated by a medical provider. Please give to the applicant's provider to complete.**
- **Section 4: Can be filled out by family but must be reviewed and approved by a medical provider. Please work with your provider's office to get Section 4 filled out completely.**

SECTION 3: Special Health Condition Information (Provider Use Only):

Note: The Special Health Condition Section must be filled out completely and signed by a medical provider licensed in the state of Montana. The treatment of services requested must be evidence-based and necessary for treatment or will greatly enhance the quality of life for the applicant. Providers will also need to initial on page 5 of the application. ***The provider's staff cannot sign for the provider.***

A. Please briefly explain the applicant's chronic physical, developmental, behavioral, or emotional condition. If the applicant does not currently have a condition, please briefly explain how the applicant is at an increased risk for a physical, developmental, behavioral, or emotional condition. More than one condition does not require multiple applications. Please attach additional pages if necessary.

_____

B. Please explain how the above condition(s) or risk of condition(s) require treatment and/or services beyond the required of children and youth generally. Please attach additional pages if necessary.

_____

Medical Information:

This information must be about the condition(s) for which the applicant is requesting assistance.

Medical Diagnosis:_____ ICD-10 Code(s):_____

Please state the length of time you have been working with this child and family:_____

_____

I attest to the medical diagnosis of the applicant listed above is true and accurate. I attest that the services in Section 3 support the treatment goals for this child and are medically necessary.

_____ _____

Medical Provider Signature Date

Medical Provider Information:

Name:_____ Credentials:_____

Phone:_____ Email Address: _____

Practice Name:_____

Mailing Address: _____

City:_____ State:_____ Zip code:_____

SECTION 4: Financial Assistance Request Information (Provider Must Sign off on request):

Note: This section must be completed for each service and/or item that is requested. If you request financial assistance for more than one service/or item, they may be on the same application. Please print additional copies of this page if more space is needed. The annual limit for financial assistance is $2,000 per qualifying child/youth. CSHS will only pay for the item(s) and/or services requested and approved on the application. ***Please Note:*** *If you are requesting assistance to purchase medical or enabling equipment, which will be purchased online, CSHS will make the purchase and have the item(s) mailed to your home. CSHS staff will contact you to make these arrangements if approved.*

Please list the requested service(s) and/or item(s). For each service/item, include a detailed description, a product link or picture for items, and the estimated cost:

_____

Provider performing the service or where the service will be purchased:_____

_____

CPT Code (if applicable): _____ Cost of estimated service:_____

Please explain why the service or item is being requested, including how it will help the health outcomes of the applicant:

_____

For financial assistance requests: Please provide the following information for the provider, health organization, agency, or business that will be receiving payment for the service (e.g., medical provider, durable medical equipment provider, pharmacist, dentist, orthodontist, surgical center, health department, transportation provider, etc.).

Medical Provider/Professional Name:_____

Department/Business Name (if applicable):_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Initials of Medical Provider (the provider who signed). By initiating, you attest that the financial request has been reviewed and will improve the health outcomes of the applicant:_____

Please check the entire application to make sure it is filled out completely.