Financial Assistance Application

Phone: 1-800-762-9891

Fax: 406-444-2750

Email: CSHS@mt.gov

Please submit your application either 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 of the document for accessibility purposes.

Children's Special Health Services (CSHS) 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 families meet a child or youth's need related to a diagnosis. Funds will not be used for items one would typically purchase for any child, but rather for items and services that specifically support progress and improved health, safety, and well-being. Applications must meet the following requirements at a minimum:

- The treatment or enabling service must be recommended by a medical professional. 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 lesser than 300% 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 in the order received 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 denial. If the application is approved, you will receive an approval letter from CSHS. Items will need to be purchased within three months of date on approval letter. Invoices for services will be approved in six-month increments from the date on approval letter. If services are going to exceed the six-month time period, families will need to resubmit insurance and financial information to 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 other resources that have been used and/or applied for to financially support the cost of the assistance being requested.

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 check to make sure all sections of the application are filled out completely and readable before submitting.

Case by case exceptions will be granted by Financial Assistance Committee

SECTION 1: Applicant & Household Information

Section must be completed entirely, or the application will not be processed. 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:

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 applicant have a primary care physician?

☐ No

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

Please indicate how many individuals:

Live in applicant's primary household:

Earn income in 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, pre-schools, 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 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.

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, 1-800-762-9891.

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 or 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 chronic 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 that 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 the medical diagnosis of the applicant listed above is true and accurate. I attest 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 are requesting financial assistance for more than one service and/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 service(s) and/or item(s) being requested. 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 or estimated cost of 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 request: Please provide the following information for provider, health organization, agency or business that will be receiving payment for the service: (ex: 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 (provider that signed). By initialing, you attest that the financial request has been reviewed and will improve the health outcomes of the applicant:

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