Special Health Care Needs (SHCN) Application

Special Health Care Needs

Kansas Department of Health and Environment

Step One
- Complete this application. If something does not apply to you or your situation, mark 'N/A' for 'Not Applicable'.

Step Two
- Ensure page 3 and 4 of the application are signed by the correct person. If child is over 18 we will need guardianship paperwork on file.

Step Three
- Include any documentation that may be requested. A list of items that may be needed are listed below.

Step Four
- Mail or fax your application to your local Satellite Office.

Financial

The following information is **required** from all financially responsible individuals living with the applicant:

☐ **If you are paid:**
- Weekly
- Every Two Weeks
- Twice A Month

We need:

Your **six (6)** most recent paystubs or paychecks. Ensure these are sequential.

☐ **If you are paid:**
- Monthly

We need:

Your **three (3)** most recent paystubs or paychecks. Ensure these are sequential.

☐ If you are **Self-Employed** we need:
- Your Profit/Loss Statements from the last **three (3)** months.

If you **do not** receive pay stubs or have been with your employer for less than three months we need:
- A statement from your employer that meets the following criteria:
  - ☐ Written on company letterhead
  - ☐ Signed and Dated by employer
  - ☐ Contains a statement of average or likely earnings and how frequently you are paid
  - ☐ Has your employer's contact information

If you are **Unemployed** we need:
- Proof of any unemployment funds or assistance you are receiving
- A letter signed and dated by yourself explaining your current situation

Please provide proof of all income being received including SSI, TANF, child support etc.

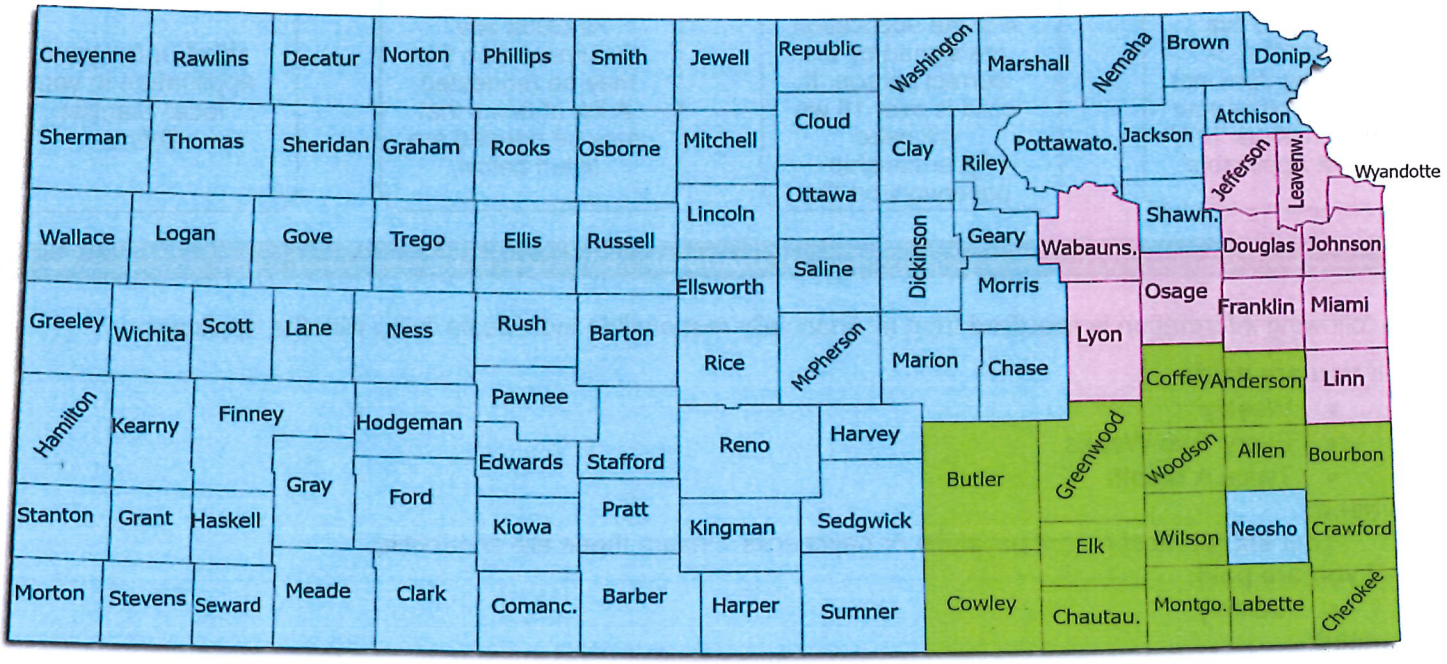
Requested Documentation

Legal Documents
- ☐ A complete copy of any divorce papers that show custody and child support agreements
- ☐ Birth Certificate if not a U.S. Citizen
- ☐ Guardianship, Power of Attorney, or other paperwork if applicant is over 18 and can not sign for themselves

Insurance Documents
- ☐ If you have private insurance, please submit a copy of the insurance card and your insurance summary page that contains your co-pay, deductible, and co-insurance information per individual

Medical Records
- ☐ If you are new to our program, sending medical records with your application will significantly expedite the application process

SHCN Offices Map



Topeka Administrative Office	1000 SW Jackson, Ste. 220 Topeka, KS 66612 P: 785.296.1313
Crawford County Health Department	410 E. Atkinson Ave. Ste A Pittsburg, KS 66762 P: 620.231.5411 F: 620.231.126
Miami County Health Department	1201 Lakemary Drive Paola, KS 66071 P: 913.294.2431 F: 913.294.9506

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Referred By: _____

Full Name: _____ **Date of Birth:** _____

Primary Language: _____

Diagnosis: _____ **Sex:** ☐ Male ☐ Female

Full Address: _____

State: _____ **City:** _____ **Zip Code:** _____

County: _____ **Phone Number:** _____

Special Services: ☐ PT ☐ OT ☐ Speech **Email Address:** _____

Current Medications: _____

Do you receive any assistance or services from another agency?: ☐ Yes ☐ No

If yes, please list them here: _____

***Ethnicity:** Are you of Hispanic, Latino or Spanish Origin? ☐ Yes ☐ No

***Race:**

☐ Native American or Native Alaskan

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ Asian

☐ White

Other: _____

**Answers to these questions are solely used to collect demographic data from our program*

Services are provided on a nondiscriminatory basis in accordance with regulations of the Department of Health and Human Services and Title VI of the Civil Rights Act of 1964. Any person who believes that discrimination on the grounds of race, color, sex, or national origin is being practiced has the right to file a complaint with the Kansas Department of Health and Environment or the Department of Health and Human Services.

Parent Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Parent(s) / Guardian(s) Living With Applicant:

Full Name: *Phone Number:* *Relationship to Applicant:*

_____

_____

Parent(s) / Guardian(s) Living Outside of Home:

Full Name: *Phone Number:* *Relationship to Applicant:*

_____

_____

Special Health Care Needs (SHCN) Application

List All Persons Living in the Household Including Applicant:

Full Name:	*Date of Birth:*	*Relationship to Applicant:*

List All Income Received:

Wages 1	
Worker's Name	
Employer	
Employer Phone	
Gross Income (Per Pay Period)	
Pay Frequency	☐ Weekly ☐ Every Two Weeks
Other:	☐ Monthly ☐ Twice A Month

Wages 2	
Worker's Name	
Employer	
Employer Phone	
Gross Income (Per Pay Period)	
Pay Frequency	☐ Weekly ☐ Every Two Weeks
Other:	☐ Monthly ☐ Twice A Month

Wages 3	
Worker's Name	
Employer	
Employer Phone	
Gross Income (Per Pay Period)	
Pay Frequency	☐ Weekly ☐ Every Two Weeks
Other:	☐ Monthly ☐ Twice A Month

Wages 4	
Worker's Name	
Employer	
Employer Phone	
Gross Income (Per Pay Period)	
Pay Frequency	☐ Weekly ☐ Every Two Weeks
Other:	☐ Monthly ☐ Twice A Month

List any SSI, SSDI, child support or other income in this field:

Type of Income	Amount Received	Received How Often

List all cash assets for all people living in your household, including checking accounts, saving accounts, cash, certificates of deposit, stocks and bonds - 401(K) and other similar retirement funds may be excluded:

Account Holder Name	Resource Type	Value

Special Health Care Needs (SHCN) Application

List Applicant's Insurance Information:
If you have private insurance, please submit a copy of your insurance card and insurance summary page that states the co-pay, deductible, and co-insurance amounts.

Name of Insurance Company	Start Date	Policy and Group Number	Deductible Per Individual	Is Dental Covered (Y/N)?

Family's Responsibilities

I Hereby Agree To the Following:

1. *If uninsured, applicant must apply for Medicaid, if applicable.*
2. *Apply for the insurance benefits and assign those benefits to the hospital, physician and suppliers of equipment and medical items ordered by the attending physician.*
3. *Apply for insurance benefits of any non-assignable insurance by making payment to the hospital, physician and suppliers of equipment and medical items ordered by the attending physician.*
4. *Repay SHCN, any insurance proceeds sent directly to me, if the insurance payment is made for treatment or equipment provided and paid for Special Health Care Needs.*
5. *I also agree to notify Special Health Care Needs within 30 days of the following:*
   - A. *The applicant acquires health insurance.*
   - B. *The applicant becomes eligible for Medicaid, Supplemental Security Income, Disability Payments, and TANF Payments or:*
   - C. *Changes in the applicant's address, income, marital status, custody of children, family income or cash assets of $500 per year or other circumstances that affect the applicant or eligible person.*

I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge. I understand that in addition to other penalties, it is illegal to obtain, attempt to obtain, or help any other person obtain, by means of a willfully false statement or representation, or by impersonation, collusion, or other fraudulent device, assistance to which they or I am not entitled, and this shall constitute the crime of theft, as defined by K.S.A. 2011 Supp. 21-5801, which could be a felony offense.

_____

Signature of Parent, Legal Guardian **OR** Social Worker If Child Is In Foster Care

_____

If Over Age 18 Signature of Applicant or Authorized Representative

_____

Date

_____

Relationship to Applicant

Special Health Care Needs (SHCN) Application

Consent for Release of Information

Applicant Name: _____ Date of Birth: _____

Full Address: _____

City: _____ State: _____ County: _____

I hereby authorize Special Health Care Needs (Special Health Services – SHCN) to obtain medical information to and from the following. Checking the boxes affirms consent:

✓	Provider Type	Provider Name	Contact Information or Location
	Hospital		
	Physician		
	School District		
	Case Worker		
	Childcare Provider		
	Medicaid / KanCare		
	Pharmacy		
	Parents as Teachers		
	Early Intervention/ KECDS		
	DCF		
	Early Head Start/ Head Start		

Expiration: This authorization shall expire one year from the date signed.

Purpose: Medical eligibility determination, care coordination and quality assurance of treatment services.

Statements of Understanding:

- I understand the potential for Special Health Care Needs to re-disclose this information and may no longer be protected by federal law.
- I understand that I may revoke this authorization at any time.
- If I revoke this authorization, it will have no effect on actions already taken in reliance of this form.
- I authorize the use or disclosure of the records/information described.
- I have read and understand this form. I have received a copy of this form.
- I am the patient listed or I am authorized to "act on behalf of the applicant/patient as the applicant's personal representative.

_____

Signature of Parent or Legal Guardian **OR** Social Worker If Child is in Foster Care

_____

Date

If Over 18 Signature of Applicant or Authorized Representative

_____

Date

If Over 18, I authorize KDHE/SHCN to discuss my financial and medical information with the following:

Name _____ **Relationship to Applicant** _____

Name _____ **Relationship to Applicant** _____

To Be Complete by SHCN Staff

Information Being Requested: _____

Information Date (Since): _____

SHCN Staff Signature _____ **Date Requested** _____