CSHCN
Children with Special Health Care Needs Program
STRENGTHENING FAMILY VOICES IN HEALTH CARE
West Virginia Department of Health and Human Resources

Application for the WV Children with Special Health Care Needs (CSHCN) Program

Referred by: ☐ Parent ☐ Legal Guardian ☐ Other Relative ☐ Medical Professional ☐ Service Provider ☐ Other

Today's Date: _____

What does the applicant need or want from CSHCN? _____

SECTION 1 Applicant's Information (List information about the person needing services)

Name *(Last, First, Middle)*	Previous Name *(if changed)*	This application is *(check one)* ☐ New ☐ Reapplying
Home Address *(Number and Street, Apartment No.)*	Social Security Number	Sex ☐ Male ☐ Female

City	State	Zip Code	Date of Birth	County of Residence

SECTION 2 Applicant's Parent/Legal Guardian/Emergency Contact Information

Parent/Guardian Name *(Last, First, Middle)*	Social Security Number

Relationship *(check one)*
☐ Mother ☐ Father ☐ Foster Parent(s) ☐ Grandparent ☐ Other Relative ☐ Legal Guardian ☐ Other

Applicant lives with *(check one)*
☐ Both Parents ☐ One Parent ☐ Foster Parent(s) ☐ Alone ☐ Spouse ☐ Legal Guardian ☐ Other

Home Phone	Work Phone	Cell Phone	Message Phone *(where you can be left a message)*

List the name(s) of those individuals, besides yourself, who have the legal right to make medical decisions for this applicant:

List the name(s) of those individuals who can obtain any or all medical information for this applicant
(i.e., including information given at medical appointments or over the phone). Only those you list can be present at clinics.

Household: List all persons living in the home including children for whom you are interested in receiving services.

Name	Date of Birth	Relationship	Occupation or Name of School

SECTION 3 | Birth Information

Birth Weight: _____ lbs. _____ oz. Delivery: ☐ Vaginal ☐ Cesarean ☐ Breech

Was your child premature? ☐ Yes ☐ No How Much? _____

What is your child's race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian and Other Pacific Islander ☐ Hispanic or Latino ☐ Other ☐ Two or more races

List any serious illness or injury during pregnancy:

List any medicine or drugs taken during pregnancy:

Did you use any of the following during pregnancy: ☐ Cigarettes ☐ Alcohol ☐ Beer If so how often: _____

List any complications during delivery:

List any problems your child had at birth:

SECTION 4 | Health History

Has or does your child now have a problem with any of the following:

Problem	Yes	No	Describe or Explain - *Continue on page 3 or attach additional pages if more space is needed.*
Serious Injuries			
Surgery/Hospitalization			
Muscles or Bones			
Walking			
Eyes/Vision			
Ears/Nose/Throat/Hearing			
Breathing/Wheezing			
Speech/Communication			
Heart			
High Blood Pressure/Cholesterol			
Bleeding Problems			
Stomach/Bowels			
Kidney/Bladder			
Eating/Feeding/Nutrition			
Seizures/Staring Spells			
Severe Headaches			
Sleeping Problems/Nightmares			
Behavior			
Hyperactivity/ADHD			
Skin			
Genetic/Chromosome Differences			
Hepatitis/Jaundice			
Reproductive			
Diabetes			
Tuberculosis/Exposure to TB			
Cancer			
Mental Health/Emotional Disorder			
Learning			
Self-Help Skills (i.e. dressing, bathing)			
Other			

SECTION 5 | Medical Information (Continue below or attach additional pages if more space is needed.)

List any medications your child is taking now (include dose and how often):

List any special equipment or supplies your child uses, and where you get them:

Check if your child is receiving special services such as: ☐ Speech ☐ Physical/Occupational Therapy ☐ Counseling
If so, where:

Does your child have any allergies? (medications, food, latex, environment) ☐ Yes ☐ No
If yes, please list and describe reaction:

Name of Applicant's Doctor/Pediatrician		Phone Number	
Address	City	State	Zip Code
Name of Applicant's Specialist:		Phone Number	
Address	City	State	Zip Code
Is the applicant currently in the hospital? ☐ Yes ☐ No	If yes, name of the hospital:		
Does the applicant have insurance coverage? ☐ Yes ☐ No	If yes, name of insurance company/HMO:		

Type of coverage: ☐ Hospital ☐ Surgery ☐ Dental ☐ Vision ☐ Prescription Drugs

NOTE TO APPLICANT: Other coverage sources (WV Medicaid, WVCHIP, or private insurance) MUST be billed for services before the CSHCN program can consider coverage of program eligible services. CSHCN does not pay insurance co-pays, deductibles, or co-insurance. This means that if another coverage source has paid for any part of the billed service(s), CSHCN WILL NOT AUTHORIZE ANY ADDITIONAL PAYMENT.

PARENT'S / CARE TAKER'S NARRATIVE:

Is there anything else you want to tell us about your child, family or home, such as:

- whether your child is worried about his/her medical problems
- what you hope your child will be able to do in the future
- directions to your home

SECTION 6 Agreement, Certification and Signature

I understand that my signature on the application indicates my agreement to the following provisions:

1. By signing this application form I am certifying that 1) the information is accurate and complete to the best of my ability, and 2) I have the legal right to request and approve care for myself or my child.
2. I understand that as an adult, an emancipated minor, or the legal guardian of the above-named child, I give my consent for medical evaluation and treatment from the Children with Special Health Care Needs (CSHCN) Program.
3. I give my permission to obtain and release medical information to programs and agencies within the WVDHHR and those programs and agencies outside the WVDHHR that are necessary for the provision of services. I understand that my or my child's personal record is confidential and may be disclosed ONLY in accordance with applicable state and federal laws.
4. I understand that the completion of the CSHCN application does not ensure eligibility to any or all of the listed programs or services offered by the Office of Maternal, Child and Family Health.
5. I understand that my or my child's eligibility for the CSHCN Program will be reviewed on a yearly basis and I will be required to provide financial and medical information to complete the review process. Failure to provide this information may result in the termination of services from the CSHCN Program.
6. I understand the importance of attending scheduled medical appointments and agree to contact the CSHCN Program when attendance is not possible. I understand that failure to attend consecutive scheduled medical appointments may result in termination of services from the CSHCN Program.
7. I agree to inform the CSHCN Program of changes in my or my child's address or phone number.
8. I understand the services of the CSHCN Program are provided without regard to race, color, or national origin according to Title VI of the Civil Rights Act of 1964.
9. I understand that I have a right to a review of any decision made by the CSHCN Program regarding my eligibility for, or receipt of, services.
10. I agree that a photocopy of this document shall be considered as effective and valid as the original.

Child's Name _____

_____ _____

Signature of Parent/Legal Guardian/or Applicant, if age 18 or over Date

MAIL THIS APPLICATION TO: *(may be faxed, but original signed application must be received before processing).*

Systems Point of Entry
West Virginia Department of Health and Human Resources
Office of Maternal, Child and Family Health
350 Capitol Street, Room 427
Charleston, West Virginia 25301-3714
Office (304) 558-5388 or Toll-Free 1 800 642-9704 FAX (304) 558-8468

Office of Maternal, Child and Family Health