SPECIAL HEALTH CARE NEEDS

Kansas Department of Health and Environment – Bureau of Family Health

*If you need assistance completing the application, please contact your **local** SHCN satellite office.*

To speed the application process please complete the entire application and include the following information:

Financial – To determine financial eligibility, we will need copies of the sources of income received by all household members who are financially responsible for applicant. Please send the following:

- ☐ Six (6) most recent pay stubs/checks, *OR* three (3) months of paystubs, if paid monthly. (If you have been with your employer for more than 3 months, paystubs are required)
- ☐ If you have been with your employer for less than 3 months, a statement of likely earnings is required on company letterhead, signed and dated by employer with employer's contact information.
- ☐ Profit/Loss statement for the last three (3) months **(Self-Employed ONLY)**

When you are unable to provide pay stubs or a statement from your employer(s), please contact the SHCN Program for assistance.

Additional information:

- ☐ Provide written documentation of additional income such as: unemployment benefits, Department of Children and Families cash assistance, SSI, disability, child support or other unearned income.
- ☐ Guardianship documentation.
- ☐ If you have private insurance, please submit a copy of the insurance card and your insurance summary page stating co-pay, deductible, co-insurance information per individual.

Please submit the following information if not currently on file with the Program. If you would like to verify what is on file please call 785-296-1313.

- ☐ If you are divorced (or became divorced since your last SHCN application) send a complete copy of your divorce papers showing custody of applicant.
- ☐ If applicant is NOT a US citizen, please send a copy of applicant's birth certificate.

- ☐ **All Signature AREAS must be signed by applicant if 18 years or older or by legal guardian. (Guardianship must be on file).**

Include client's name in all documentation submitted.

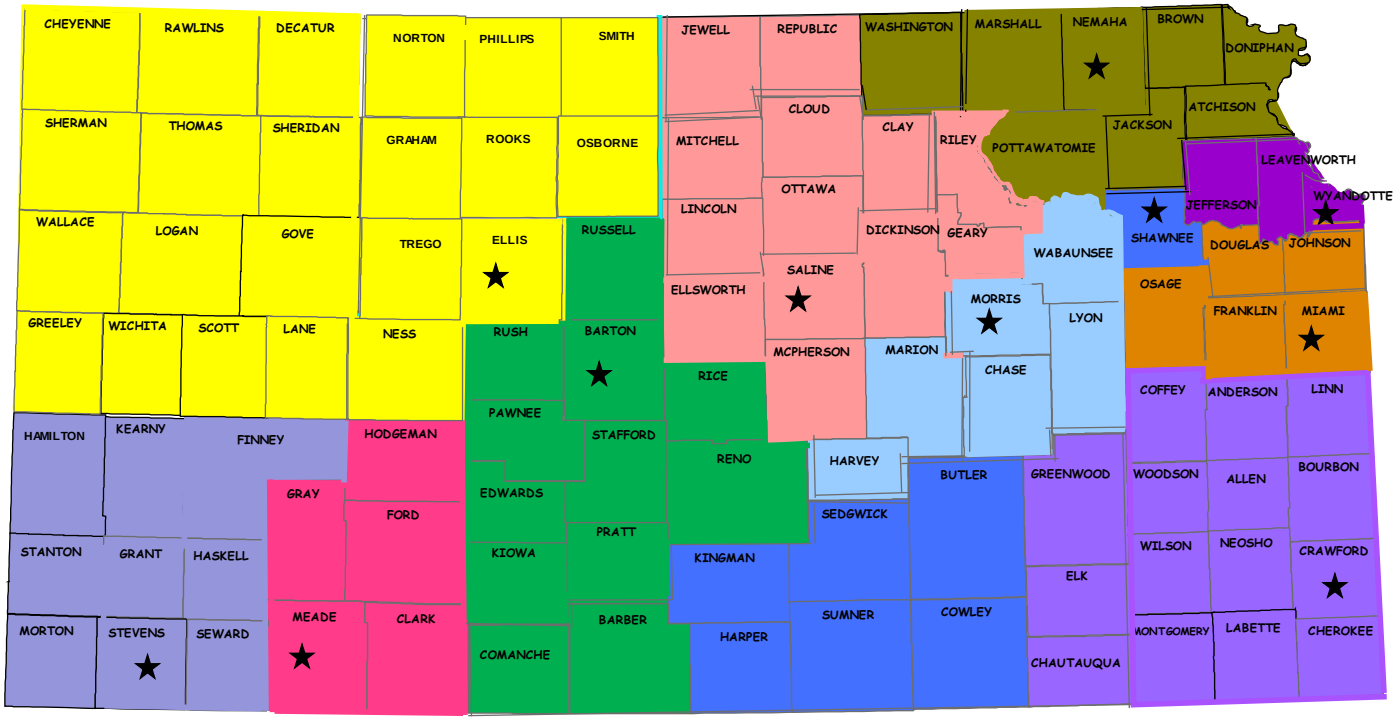
Failure to complete any part of the application or consent form will result in the application or forms being sent back to you for completion. This will delay the application process until the fully completed form is returned.

Complete applications will be processed in the order they are received. If something does not apply to you or your situation, mark N/A for "not applicable." Otherwise, the application may be viewed as incomplete. Application may be submitted electronically via email or by mail/fax to your assigned satellite office (see map and information on the back).

**** PLEASE KEEP A COPY FOR YOUR RECORDS***

Special Health Care Needs

SHCN Satellite Offices – SFY 2019



Topeka Administrative SHCN Office
1000 SW Jackson Ave, Suite 220, Topeka, KS 66612
Toll free: 1-800-332-6262 ~ Local: 785-296-1313 ~ Fax: 785-559-4238

Barton County Health Department
1300 Kansas Ave., Great Bend, KS 67530
Local: 620-793-1902 ~ Fax: 620-793-1903

Crawford County Health Department
410 E. Atkinson, Suite A, Pittsburg, KS 66762
Local: 620-231-5411 ~ Fax: 620-231-1246

Ellis County (Hays Area Children's Center)
94 Lewis Dr., Hays, KS 67601
Local: 785-625-3257 ~ Fax: 785-625-8557

Meade County Health Department
309 S. Webb/PO Box 248, Meade, KS 67864
Local: 620-873-8745 ~ Fax: 620-873-8749

Miami County Health Department
1201 Lakemary Dr., Paola, KS 66071
Local: 913-249-2431 ~ Fax: 913-249-9506

Morris County Health Department
221 Hockaday St., Council Grove, KS 66846
Local: 620-767-5175 ~ Fax: 620-767-6880

Nemaha County Community Health Services Inc.
1004 Main St., Sabetha, KS 66534
Local: 785-284-2152 ~ Fax: 785-284-3827

Saline County Health Department
125 W. Elm St., Salina, KS 67401
Local: 785-826-6600 ~ Fax: 785-826-6605

Stevens County Health Department
505 S. Polk St., Hugoton, KS 67951
Local: 620-554-7177 ~ Fax: 620-554-2006

Unified Government Health Department
619 Ann Ave., Kansas City, KS 66101
Local: 913-573-8863 ~ Fax: 913-573-8885

SPECIAL HEALTH CARE NEEDS (SHCN) APPLICATION

Special Health Care Needs

Kansas Department of Health and Environment

Referred By: _____

Applicant's Name: _____**Birth Date:**_____

Sex: ☐ **Male** ☐ **Female** **Social Security # (Optional)** _____

Other Name/AKA_____ **Email Address** _____

Applicant or Parent Phone Number (___)_____

Applicant's Diagnosis _____

Home Address: _____ **Apt. #** _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____

School or Early Intervention Services_____

School District _____ **Phone:** (___)_____

Special Services: ☐ **OT** ☐ **PT** ☐ **Speech** ☐ **Counseling** ☐ **Other (Please List)** _____

Current Medications **Name, Address and Phone Number of Pharmacy**

_____ _____

_____ _____

_____ _____

Do you speak English? ☐ **Yes** ☐ **No** **If No, language spoken:** _____

Contact Person Who Speaks English: _____ **Phone #:** (___)_____

Are you or your child currently receiving services from a waiver program: ☐ **Yes** ☐ **No**

If yes, which waiver? _____

Who is your case manager/target case manager or person who assists you with services?

_____

What type of assistance do they provide you with? _____

If you or your child have KanCare who is your Case Manager? _____

Do you or your child receive assistance coordinating care from another agency/organization? _____

If yes, what other agency/organization are you receiving from? _____

What type of assistance do they provide you with? _____

SPECIAL HEALTH CARE NEEDS (SHCN) APPLICATION

Applicant's Name: _____ **Birth Date:** _____

*Requested Information Regarding Applicant**

Race:

Ethnicity:

**The answer will not affect eligibility. The answer will be used to collect information about people who apply for the program.*

- ☐ American Indian
- ☐ Native Alaskan
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Caucasian
- ☐ Other_____

- ☐ Hispanic or Latino
- ☐ Not Spanish/Hispanic/Latino
- ☐ Puerto Rican
- ☐ Mexican
- ☐ Cuban
- ☐ Other Hispanic or Latino
- ☐ Hispanic
- ☐ Other_____

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

Parent/Applicants Marital Status:

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name of Parent(s) and Phone Number (where child lives) (Check to indicate step-parent)

Last First MI Phone Number

_____(___)_____ ☐

_____(___)_____ ☐

Name of parent and phone number NOT living with child

Last First MI Phone Number

_____(___)_____ ☐

_____(___)_____ ☐

Name of Legal Guardian if Different from Parents: _____

Phone Number: (___)_____

Home Address: _____ **Apt. #** _____

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

SPECIAL HEALTH CARE NEEDS (SHCN) APPLICATION

Special Health Care Needs

Kansas Department of Health and Environment

Applicant's Name: _____ Birth Date: _____

List ALL the income received by people living in your household (related & non-related). Be sure to include all sources of gross income (before taxes) such as wages, dividends and interest, assistance from DCF (TANF, food stamps), SSI, annuities, pensions, disability, child support, alimony, unemployment and other unearned income. Financial Information will be verified prior to service authorization. (*If there is additional income please list on a separate sheet*)

Name	Employer Name	Work / Phone #	Gross Amount	How Often
			$	☐ Weekly ☐ every 2 weeks ☐ twice a month ☐ monthly
			$	☐ Weekly ☐ every 2 weeks ☐ twice a month ☐ monthly
			$	☐ Weekly ☐ every 2 weeks ☐ twice a month ☐ monthly

	Amount	How Often
Food Stamps:	$_____	_____
SSI Income:	$_____	_____
SSDI Income:	$_____	_____
Child Support:	$_____	_____

List all the cash assets for all people living in your household (include cash, checking/savings accounts, certificates of deposit, stocks & bonds) excluding 401(k) and retirement.

Type of Resources	Primary Account	Value
		$
		$

Applicant's Insurance Information (If you have private insurance, please submit a copy of the insurance card and your insurance summary page stating co-pay, deductible, co-insurance information per individual)

Applied for Medicaid/ KanCare Yes / No	Name of Insurance Company	Start Date	Policy & Group Number	Deductible per Individual	Dental Orthodontic Coverage Yes / No	Receiving SSI Yes / No

Other health insurance coverage available for applicant

Name of Insurance Company	Start Date	Policy & Group Number	Deductible per Family/Individual	Dental/Orthodontic Coverage Yes / No

SPECIAL HEALTH CARE NEEDS (SHCN) APPLICATION

Applicant's Name: _____ Birth Date: _____

List all the people living in the household (related and non-related)

Name	Relationship	Date of Birth	Insurance Coverage Yes / No

FAMILY'S RESPONSIBILITIES-I HEARBY AGREE TO:

If uninsured, applicant must apply for Medicaid, if applicable.
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.
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.
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.

I also agree to notify Special Health Care Needs within 30 days of the following:

- **The applicant acquires health insurance.**
- **The applicant becomes eligible for Medicaid, Supplemental Security Income, Disability Payments, and TANF Payments or**
- **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, applicant if over age 18 or authorized representative

_____

Relationship to Applicant

_____

Date

Special Health Care Needs

CONSENT FOR RELEASE OF INFORMATION

Kansas Department of Health and Environment

Applicant's Name: _____ **Birth Date:** _____

Home Address: _____ **Apt. #:** _____

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). Please include contact information.

- ☐ Hospital _____
- ☐ Parents As Teachers _____
- ☐ School District # _____
- ☐ Case Worker _____
- ☐ Childcare Provider _____
- ☐ Kansas Department for Children and Families
- ☐ Other _____
- ☐ Other _____
- ☐ Physician _____
- ☐ Medicaid/KanCare _____
- ☐ Private Insurance _____
- ☐ CDDO _____
- ☐ Early Head Start/Head Start _____
- ☐ TRICARE _____
- ☐ Other _____
- ☐ Other _____

Expiration: This authorization shall expire one year from the date signed.
Purpose: Medical eligibility determination, care coordination, 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.

_____ _____
Parent/Guardian Signature, if applicant is over 18 **Date**

IF OVER 18: I authorize KDHE/SHCN to discuss my financial and medical information with the following individuals:

_____ _____
Name **Relationship to Applicant**

_____ _____
Name **Relationship to Applicant**

OVER

CONSENT FOR RELEASE OF INFORMATION

TO BE COMPLETED BY SHCN STAFF

Information Being Requested: _____

Medical Record Information (since): _____ **Date Requested:** _____