

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 Regional SHCN 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, OR 3 months of paystubs, if paid monthly.
- Statement of likely earnings for the next 3 months from the employer(s) - on company letterhead, signed and dated by employer with employer contact information ,
 - 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.
- 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.
- Profit/Loss statement for the last three (3) months (Self-Employed ONLY)

When you are unable to provide pay stubs/checks or a statement from your employer(s), you may send us one or more of the following to verify current yearly household income; however, this will be accepted only with the SHCN Program Manager's approval.

- The last federal income tax form (1040 or 1040A)
- W-2's for all persons financially responsible for applicant in the household

Additional information:

- 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 (if not previously submitted).
- If applicant and/or other employed member of the household is known by any other name(s), please include those names on the application in the section listed "Alias of Applicant and/or Parents."
- Guardianship documentation

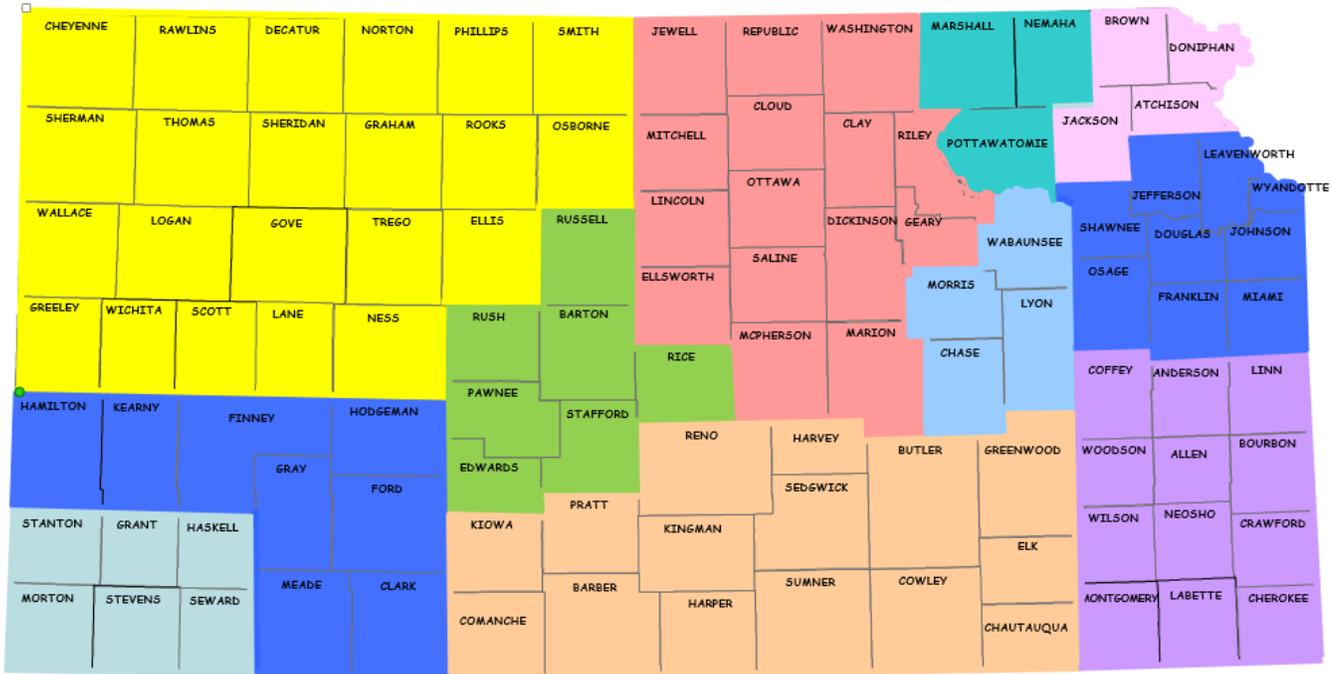
Consent form (page 3) - This release of information MUST be completed and signed. Consent must be signed by applicant if 18 years or older (or by legal guardian).

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. This application may be submitted electronically via email or by mail/fax to your assigned regional office (see map and information below).



SPECIAL HEALTH CARE NEEDS PROGRAM SATELLITE OFFICE



Topeka Administrative SHCN Office

1000 SW Jackson Ave, Suite 220, Topeka, KS 66612
 Toll free: 1-800-332-6262
 Local: 785-296-1313 ~ Fax: 785-296-8616
www.kdheks.gov/shcn

Barton County

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: 620-235-7135

Hays Area Children's Center

94 Lewis Dr., Hays, KS 67601
 Local: 785-625-3257 ~ Fax: 785-625-8557

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 Street, Sabetha, KS 66534
 Local: 785-284-2152 ~ Fax: 785-284-3827

Northeast Kansas Multicounty Health Department

907 S 2nd St., Hiawatha, KS 66434
 Local: 785-742-2505 ~ Fax: 785-742-7988

Saline County Health Department

125 W Elm, Salina, KS 67401
 Local: 785-826-6600 ext./ 260 ~ Fax: 785-826-6605

Stevens County Health Department

505 S Polk St., Hugoton, KS 67951
 Local: 620-544-7177 ext. 16 ~ Fax: 620-544-2006

University of Kansas School of Medicine – Wichita

551 N. Hillside, Suite 250, Wichita, KS 67214
 Local: 316-962-2021 ~ Fax: 316-962-2017

SPECIAL HEALTH CARE NEEDS (SHCN) APPLICATION

Indicate with N/A or "not applicable" for items that do not apply to you or your situation. Otherwise, the application may be viewed as incomplete.

NAME OF APPLICANT (individual needing services)				Birth date	SEX	Social Security Number	Mother's Maiden Name
Last		First	MI		M/F		
Alias of Applicant and or Parents			Email Address	Applicant or Parent Phone Number		()	
Applicant's diagnosis or reason for applying							
Home Address			Apt #	City	State	ZIP	County
School or Early Intervention Services		School District	Phone Number	Special Services			
			()	OT <input type="checkbox"/> PT <input type="checkbox"/> SPEECH <input type="checkbox"/> COUNSELING <input type="checkbox"/> OTHER (PLEASE LIST):			
Current Medications (attached extra pages if needed)			Name and Address of Pharmacy			Phone Number	
						()	
						()	
						()	
						()	
IS APPLICANT A LEGAL US RESIDENT?				YES <input type="checkbox"/>	NO <input type="checkbox"/>	IS APPLICANT A LEGAL US CITIZEN?	
Do you speak English?		YES <input type="checkbox"/> NO <input type="checkbox"/>	If no, language spoken	Contact Person Who Speaks English		Phone	()
Requested Information Regarding Applicant *							Ethnicity: Hispanic or Latino <input type="checkbox"/>
Race: American Indian or Native Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian or Other Pacific islander <input type="checkbox"/> White <input type="checkbox"/> Other (specify) <input type="checkbox"/> _____							
<i>*The answer will not affect eligibility. The answer will be used only to collect information about people who apply for the program</i>							
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 or with both.							
Parent/Applicants	NAME OF PARENT(S) (where child lives) (check to indicate step-parent)			Phone Number	Name of parent NOT living with child		Phone Number
Marital Status	Last	First	MI		Last	First	MI
Married <input type="checkbox"/> Single <input type="checkbox"/>				()			()
Widowed <input type="checkbox"/>				()			()
Divorced <input type="checkbox"/>				()			()
Separated <input type="checkbox"/>				()			()
Name of Legal Guardian if Different from Parents:			Phone Number	Address	Apt #	City	State
Last	First	MI					ZIP
			()				
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.							
Name of person(s) working or receiving money. Attach extra sheet if needed	Who provides the money? Name of employer, program or person, please specify.			Work Phone Number	How often? Weekly, every 2 wks, twice a month, or monthly		What amount? (GROSS)
1.				()			
2.				()			
3.				()			

SPECIAL HEALTH CARE NEEDS (SHCN) APPLICATION

Indicate with N/A or "not applicable" for items that do not apply to you or your situation. Otherwise, the application may be viewed as incomplete.

Applicant's Name		Birth date	
------------------	--	------------	--

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

Types of Resources	Primary Account Holder	Value
1.		
2.		
3.		

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

Names (attach extra sheet if needed)	Relationship to applicant	Date of Birth	Applied for Medicaid	Name of Insurance Company	Start Date	Policy & Group Number	Deductible per Family/individual	Dental Orthodontic coverage Yes/No	Receiving SSI Yes/No
Last First									
1.	(Applicant)								
2.									
3.									
4.									
5.									

Other health insurance coverage available for applicant (available such as from parent not living at home or grandparent)

Names (attach extra sheet if needed)	Relationship to applicant	Name of Insurance Company	Start Date	Policy & Group Number	Deductible per Family/individual	Dental/Orthodontic coverage Yes/No
Last First						
1.						
2.						

FAMILY'S RESPONSIBILITIES-I hereby agree to:

- 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 Children and Youth with 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, guardian, applicant if over age 18 or authorized representative

Relationship to Applicant

Date

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
 SPECIAL HEALTH CARE NEEDS (SHCN)
 1000 SW Jackson, Suite 220, Topeka, Kansas 66612-1274
 (785) 296-1313 or Toll Free 1-800-332-6262 or (785)-296-8616 (fax)
<http://www.kdheks.gov/SHCN>

Consent For Release of Information

Applicant's Name					Birth date	
Home Address	Apt#	City	State	ZIP	County	

I hereby authorize Special Health Care Needs (Special Health Services-SHCN) to obtain medical information from the following doctors, hospitals and team clinics.

Primary Care Physician	Address (REQUIRED)	City, ST ZIP	Phone
Specialist or Hospital	Address (REQUIRED)	City, ST ZIP	Phone

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 patient as the patient's personal representative."

 Signature of Parent, guardian, applicant if over age 18, or authorized representative

 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: _____

TO BE COMPLETED BY SHCN STAFF

Information Being Requested: _____ Medical record information (since) _____

Date Requested _____