Children with Special Health Care Needs (CSHCN) Program
SPECIALTY CARE INTAKE FORM (SCIF)

Purpose: To make application to the Children with Special Health Care Needs Program and referral for any or all of the programs or services offered by the Office of Maternal, Child and Family Health

Today's Date: _____/_____/_____

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	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.**

In the event of an emergency or natural disaster (flood, etc.) what special needs does the applicant require (i.e., electricity for equipment, special precautions for allergies, wheelchair dependent, special medications)?

May we share this information, if requested, to an Emergency Responder in your area who may assist you? ☐ Yes ☐ No

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 – Health Information

What are the applicant's major health problem(s):			
Name of Applicant's Doctor/Pediatrician:		Phone No.:	
Address	City	State	Zip Code
Name of Applicant's Specialist:		Phone No.:	
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			
List treatments, medical equipment, nutritional supplements and medications NOT covered by your insurance/HMO:			
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.**			
Please indicate what services listed below your child currently or previously received by placing a "C" or "P" on the line next to the appropriate program. **C=Current P=Previously**			
☐ WV Medicaid ID No. _____	☐ Health Check (EPSDT)	☐ MRDD Waiver (Title XIX)	
☐ WV CHIP ID No. _____	☐ WV Birth to Three	☐ WIC	
☐ SSI/DDS	☐ Right From The Start (RFTS)		
☐ Other, please specify:			

Section 4 – 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 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 Specialty Care Intake Form (SCIF) does not insure 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