

OFFICE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

(OCSHCN) APPLICATION FOR SERVICE

(OCSHCN Use Only - CUP ID)

This application must be signed and dated by the legal guardian of the patient/child applying for service.

1. Patient Information

Name First		Middle	Last	
Date of Birth ____/____/____		Patient's Social Security Number ____/____/____		Patient's Biological Sex ☐ Male ☐ Female
Patient's Race/Ethnicity (One or more categories may be selected)				
☐ American Indian or Alaska Native	☐ Bi-racial Hispanic/Other Combination	☐ White		
☐ Asian	☐ Black or African American	☐ Other _____		
☐ Asian Indian	☐ Hispanic or Latino	☐ Decline to answer		
☐ Bi-racial Black/White	☐ Native Hawaiian or Other Pacific Islander	☐ Unknown		
Primary language spoken in home: ☐ English ☐ Spanish ☐ Swahili ☐ Arabic ☐ French ☐ ASL ☐ Burmese ☐ Somali ☐ Other _____				
Is an interpreter needed for ☐ Patient? ☐ Legal Guardian?				
Address where Patient resides P.O. Box is not acceptable.				
Street Number and Name				Apt. #
City	State	Zip Code	County	

2. Legal Guardian Information

The biological/adoptive parents of the Patient are: ☐ Married to each other ☐ Divorced from each other Mother remarried? ☐ Yes ☐ No Father remarried? ☐ Yes ☐ No ☐ Separated ☐ Legally separated ☐ Never married to each other ☐ Cohabitant/Live together with child ☐ Other _____		Who is/are the Legal Guardian(s) of the Patient? If more than one legal guardian, <u>CHECK ALL that apply</u>. If divorced or legally separated parents share joint custody of the child, BOTH PARENTS MUST be identified as Legal Guardians. ☐ Mother (biological/adoptive) ☐ Father (biological/adoptive) ☐ Commonwealth of Kentucky ☐ Other _____		
1) Legal Guardian's Name First		Middle		Last
Legal Guardian's Relationship to Patient ☐ Mother ☐ Father ☐ State Social Worker ☐ Other _____				
Legal Guardian's Address if different from Patient				
Street Number and Name				Apt. #
City	State	Zip Code	County	

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Legal Guardian's Mailing Address if different from street address				
P.O. Box # or Street Number and Name				Apt. #
City	State	Zip Code	County	
Legal Guardian's Contact Information				
Cell phone ()	Home phone ()	Email		
2. Legal Guardian Information, Continued				
2) Legal Guardian's Name First		Middle	Last	
Legal Guardian's Relationship to Patient ☐ Mother ☐ Father ☐ State Social Worker ☐ Other _____				
Legal Guardian's Address if different from Patient				
Street Number and Name				Apt. #
City	State	Zip Code	County	
Legal Guardian's Mailing Address if different from street address				
P.O. Box # or Street Number and Name				Apt. #
City	State	Zip Code	County	
Legal Guardian's Contact Information				
Cell phone ()	Home phone ()	Email		
3. Required if Patient DOES NOT live with the Legal Guardian(s)				
Name of Other Adult(s) or Residential Facility				
Cell phone ()	Home phone ()	Email		
Relationship to Child ☐ Foster Parent ☐ Grandparent ☐ Residential Facility ☐ Other _____				
4. Medical Information				
For what medical condition(s) are you requesting the Patient to be evaluated/treated through OCSHCN?				
Does the Patient have transportation to medical appointments? ☐ Yes ☐ No				
Who referred the Patient to OCSHCN for Service? ☐ Primary Care Physician ☐ Specialist _____ ☐ Hospital ☐ School ☐ Self-Referral ☐ Other _____				
Patient's Primary Care Physician or Practice	Name		Phone number ()	
Address		City	State	Zip Code

5.a Insurance Information (MEDICAID)Does the Patient currently have Medicaid coverage? ☐ Yes ☐ No If yes, check the type of Medicaid plan:

- | | | |
|--|--|--------------------------------|
| ☐ Aetna Better Health of KY | ☐ Passport Health Plan by Molina | ☐ Other |
| ☐ Humana Healthy Horizons in KY | ☐ UnitedHealthcare Community Plan | |
| ☐ KY Medicaid (without MCO) | ☐ WellCare of KY | |

Plan ID Number _____ Medicaid ID Number _____

*****A COPY OF THE INSURANCE CARD (front and back) MUST BE SUBMITTED WITH THIS FORM.*****

5.b Insurance Information (PRIVATE INSURANCE)Does the Patient currently have private insurance coverage? ☐ Yes ☐ NoIf yes, list *each* Medical, Dental, or Vision policy under which the Patient is covered.

*****A COPY OF THE INSURANCE CARD(S) (front and back) MUST BE SUBMITTED WITH THIS FORM.*****

Policy Holder's Name	Date of Birth	Type of Insurance
	/ /	☐ Medical ☐ Dental ☐ Vision
Insurance Carrier Name	Policy ID Number	Group Number
Policy Holder's Name	Date of Birth	Type of Insurance
	/ /	☐ Medical ☐ Dental ☐ Vision
Insurance Carrier Name	Policy ID Number	Group Number

5.c Insurance Information (UNINSURED)

If Patient has no health insurance, please indicate the reason:

- ☐ Religious exemption ☐ Non-U.S. Citizen (undocumented) exemption
- ☐ Waiting on insurance to be active ☐ Chose not to apply for Medicaid or Private Insurance
- ☐ Other _____

6. Required Signature

I, the undersigned, hereby certify that all statements made in this application are true and correct to the best of my knowledge and belief. I understand that failure to provide complete and accurate information on this application form and/or failure to provide required proof of custody, income and/or insurance will result in this application being denied. I further understand that completion of this application does not guarantee receipt of OCSHCN service(s).

Signature _____ Date _____

Signature of Legal Guardian (required)

(required)

Print Name _____