

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 ☐ 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 of PCP		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
☐ Humana Healthy Horizons in KY
☐ KY Medicaid (without MCO)

☐ Passport Health Plan by Molina
☐ UnitedHealthcare Community Plan
☐ WellCare of KY
☐ Other

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
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 _____

If Patient currently has Medicaid coverage, skip sections 6 and 7 below.

Application must be signed and dated on page 5.

6. Required Household Family Member InformationFamily Members must be listed below. A Household Family Member only includes:the Child's biological/adoptive parent(s), stepparent, siblings, half-siblings or stepsiblings, and any other person eligible to be claimed as a dependent by the parent/stepparent on a Federal tax return.**DO NOT LIST THE PATIENT IN THIS SECTION.****Household/Family Members**

First Name	M.I.	Last Name	Date of Birth
Family Member's Relationship to Patient ☐ Mother ☐ Father ☐ Stepparent ☐ Sibling, Half-Sibling or Stepsibling			

Household/Family Members, continued			
First Name	M.I.	Last Name	Date of Birth
Family Member's Relationship to Patient ☐ Mother ☐ Father ☐ Stepparent ☐ Sibling, Half-Sibling or Stepsibling			
First Name	M.I.	Last Name	Date of Birth
Family Member's Relationship to Patient ☐ Mother ☐ Father ☐ Stepparent ☐ Sibling, Half-Sibling or Stepsibling			
First Name	M.I.	Last Name	Date of Birth
Family Member's Relationship to Patient ☐ Mother ☐ Father ☐ Stepparent ☐ Sibling, Half-Sibling or Stepsibling			
First Name	M.I.	Last Name	Date of Birth
Family Member's Relationship to Patient ☐ Mother ☐ Father ☐ Stepparent ☐ Sibling, Half-Sibling or Stepsibling			

7. Required Household Income information

Check all family members who received TAXABLE INCOME in the previous 12-month period.

☐ Patient ☐ Mother ☐ Father ☐ Stepparent ☐ None ☐ Other

Proof of income MUST be submitted with this application. For each family member who received any TAXABLE INCOME in the previous 12-month period, you must provide the following documentation:

- Most recent Federal Tax Return (Form 1040) including all schedules
- Pay stub or statement with year-to-date earnings (or 2 consecutive pay stubs)

Examples of Taxable Income

- Wages, Salaries, Tips, Commissions • Social Security Benefits • Railroad Retirement Benefits
- Pension(s) • Unemployment Compensation • Real Estate Rentals • Business/Farm Income
- Partnerships • S. Corporations • Interest/Dividend/Annuity Distribution(s) • Estates & Trusts
- IRA Distributions • Capital and Other Gains/Losses • State & Local Tax Refunds • Royalties
- Alimony • Other (prizes, awards, jury duty, gambling winnings, etc.)

Check all family members who received NON-TAXABLE INCOME in the previous 12-month period.

☐ Patient ☐ Mother ☐ Father ☐ Stepparent ☐ None ☐ Other

Proof of income MUST be submitted with this application. For each family member who received any NON-TAXABLE INCOME in the previous 12-month period, you must provide the following documentation:

- A statement from payer specifying amount received and frequency of payment
- If applicable: Copy of most recent executed court ordered Judgment for Child Support or statement issued by CHFS, Department of Income Support, showing child support received in last 12 months for all children in household

Examples of Non-Taxable Income

- Child Support • Supplemental Security Income Benefit (SSI) • Workers Compensation Award
- Veterans Disability Benefits • Minister/Military Cash Allowance(s) • Retirement Survivors Disability Insurance (RSDI) • Damages for Physical Injury or Sickness (Excluding Black Lung)

No Income: If you have indicated that there is no income coming into the household of the Patient for whom service is being requested, specify how the Patient is being supported.

Please Note: Additional income documentation may be requested if needed to determine program eligibility.

8. 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 _____