OFFICE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS (OCSHCN)
APPLICATION FOR SERVICE

OCSHCN-10e (01 2019)
C-8 YA (Young Adult)

WHEN COMPLETING THIS APPLICATION FORM PLEASE PRINT.

THIS APPLICATION FORM:

MUST be completed in INK, and

MUST be signed and dated by the Applicant (i.e., the person who will receive care through the OCSHCN if determined eligible for its program).

Only forms with original signatures can be processed. Copies, including faxes, are not acceptable.

RETURN COMPLETED APPLICATION TO OCSHCN

SECTION 1 Required General Information

Your (Applicant's) Name: _____ (First) _____ (Middle) _____ (Last)

Date of Birth ____/____/_____ (xx xx xxxx)

Social Security #_ ____/____/_____ (xxx xx xxxx)

Sex ☐Male ☐Female

Are You married ☐Yes ☐No

Home (street) address where You permanently reside: _____ (Street number and name) _____ (APT #)
P.O. Box Mailing Address is not acceptable

_____ (City) _____ (State) _____ (Zip Code) _____ (County)

Your primary language
☐English ☐Spanish ☐Sign Language-ASL
☐Sign Language-SEE ☐Bosnian ☐Korean
☐German ☐Chinese ☐Russian
☐French ☐Vietnamese ☐Arabic
☐Other _____ (Specify)

Do You need an Interpreter? ☐ Yes ☐ No

Your Mailing address. Enter Only if different from Your Street address. _____ (P.O. Box # or Street number and name) _____ (APT #) _____ (City) _____ (State) _____ (Zip Code) _____ (County)

Your
Home phone: (____)_____ Cell phone: (____)_____ Work phone: (____)_____ Fax #: (____)_____ Email_____

Who referred You to OCSHCN for Service?

☐ Primary Care Physician ☐ Specialist (M.D.) _____ (Name of Doctor or Practice) ☐ Hospital ☐ School ☐ Self-Referral ☐ Health Department

☐Other _____(Specify)

Who is Your Primary Care Doctor _____ (Name of Doctor or Practice) Office phone number : (_____)_____

Address of Primary Care Doctor's Office _____ (Street number and name) _____ (City) _____ (State) _____ (Zip Code) _____ (County)

What is/are the medical condition(s) for which You are requesting to be evaluated/treated through OCSHCN?

Do You have transportation to Medical Appointments? ☐ Yes ☐ No

Are You a full-time student? ☐ Yes ☐ No If yes, name of school _____

How did You learn/hear about the OCSHCN? From: ☐ a family member ☐ a friend ☐ the Internet ☐ the newspaper/brochure/mailing ☐ TV ☐ Radio

SECTION 2 Required Insurance Information

1. Do You currently have Medicaid Coverage? ☐ Yes ☐ No

If Yes, check the Medicaid plan under which You have coverage. **A COPY OF THE INSURANCE CARD (front and back) MUST BE SUBMITTED WITH THIS APPLICATION**

☐ Aetna Better Health ☐ Humana CareSource ☐ Anthem Health Plan ☐ Passport Health Plan ☐ WellCare Health Plan ☐ Medicaid ☐ Other _____(Specify)

What is Your Plan ID number?_____

2. Do You currently have private insurance coverage? ☐ Yes ☐ No

If yes, list ***each*** Medical, RX, Dental and/or Vision plan/policy under which You are covered. **A COPY OF THE INSURANCE CARD(S) (front and back) MUST BE SUBMITTED WITH THIS APPLICATION**

Name of Insurance Carrier	Type of Insurance Coverage	Policy/Plan ID Number	Policy Holder's Name	Policy Holder's Date of birth	Policy Holder's Social Security No.
	☐ Medical ☐ RX ☐ Dental ☐ Vision		_____ _____ _____ First Middle Last	___/___/_____ xx xx xxxx	___/___/_____ xxx xx xxxx
Name of Insurance Carrier	Type of Insurance Coverage	Policy/Plan ID Number	Policy Holder's Name	Policy Holder's Date of birth	Policy Holder's Social Security No.
	☐ Medical ☐ RX ☐ Dental ☐ Vision		_____ _____ _____ First Middle Last	___/___/_____ xx xx xxxx	___/___/_____ xxx xx xxxx
Name of Insurance Carrier	Type of Insurance Coverage	Policy/Plan ID Number	Policy Holder's Name	Policy Holder's Date of birth	Policy Holder's Social Security No.
	☐ Medical ☐ RX ☐ Dental ☐ Vision		_____ _____ _____ First Middle Last	___/___/_____ xx xx xxxx	___/___/_____ xxx xx xxxx

NOTE: *If additional insurance, list on separate piece of paper and submit with this form. Copy of card(s) must be submitted.*

3. If you are uninsured, are you exempt from the requirement to have insurance coverage under the Affordable Care Act (ACA/Obamacare)? ☐ Yes ☐ No

If yes, check reason: ☐ Non U.S. Citizen-undocumented ☐ Religious exemption ☐ Household income below threshold for filing tax return ☐ The cost of coverage more than 8% of household income ☐ Without coverage for < 3 months ☐ Member of Health care sharing ministry ☐ Determined by Health Benefit Exchange to have hardship in obtaining coverage ☐ Member of exempt Indian Tribe ☐ Incarcerated

If You currently have Medicaid coverage, skip sections 3 and 4 below. (Note: Application must be signed and dated at the bottom of page 4)

SECTION 3 Required Household Family Member Information

Family members with whom YOU live must be listed below. A Household Family Member only includes: Your biological/adoptive parent(s), step-parent, sibling(s), half/step brother(s)/sister(s) and any other person eligible to be claimed as a *dependent child* by Your parent(s)/step-parent on a Federal tax return. Do not list Yourself in this section.

Family Member's Name: First Middle Last	Date of Birth XX /xx /xxxx	Check one: Your : ☐mother ☐father ☐step-parent ☐sibling ☐half/step-brother/sister or ☐other person eligible to be claimed as a dependent child . SPECIFY relationship to parent/step-parent
_____ _____ _____	___/___/___	_____
_____ _____ _____	___/___/___	_____
_____ _____ _____	___/___/___	_____
_____ _____ _____	___/___/___	_____

Family Member's Name: First _____ Middle _____ Last _____	Date of Birth ___/___/___ XX /xx /xxxx	Check one: Your : ☐mother ☐father ☐step-parent ☐sibling ☐half/step-brother/sister or ☐other person eligible to be claimed as a dependent child . SPECIFY relationship to parent/step-parent

NOTE: *If additional family members, list on separate piece of paper and submit with this application*

SECTION 4 **Required Household Family Income Information**. **Required Proof of Income MUST be submitted with this application. (Refer to the Instruction sheet for further details)**

Your income and the income of Your parent(s) and step-parent with whom you live must be provided below. Complete only the columns that are applicable.

*For each person, mark **all** income received currently and during the previous 12 months. If no income was/is received, You MUST mark "NONE".*

Your Income	**Non Taxable Income** ☐Child Support ☐Supplemental Security Income Benefit (SSI) ☐Workers Compensation Award(s) ☐Veterans Disability Benefits ☐Minister/Military Cash Allowance(s) ☐Retirement Survivors Disability Insurance (RSDI) ☐Damages for Physical Injury or Sickness (Excluding Black Lung) ☐ NONE	**Federal 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(s)/Dividend(s) ☐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.) ☐ NONE
Income of Your **Mother** (legal guardian) living in household	**Non Taxable Income** ☐Child Support ☐Supplemental Security Income Benefit (SSI) ☐Workers Compensation Award(s) ☐Veterans Disability Benefits ☐Minister/Military Cash Allowance(s) ☐Retirement Survivors Disability Insurance (RSDI) ☐Damages for Physical Injury or Sickness (Excluding Black Lung ☐ NONE	**Federal 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(s)/Dividend(s) ☐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. ☐ NONE
Income of Your **Father** (legal guardian) living in household	**Non Taxable Income** ☐Child Support ☐Supplemental Security Income Benefit (SSI) ☐Workers Compensation Award(s) ☐Veterans Disability Benefits ☐Minister/Military Cash Allowance(s) ☐Retirement Survivors Disability Insurance (RSDI) ☐Damages for Physical Injury or Sickness (Excluding Black Lung ☐ NONE	**Federal 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(s)/Dividend(s) ☐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. ☐ NONE
Income of Your **Step-parent** living in household	**Non Taxable Income** ☐Child Support ☐Supplemental Security Income Benefit (SSI) ☐Workers Compensation Award(s) ☐Veterans Disability Benefits ☐Minister/Military Cash Allowance(s) ☐Retirement Survivors Disability Insurance (RSDI) ☐Damages for Physical Injury or Sickness (Excluding Black Lung ☐ NONE	**Federal 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(s)/Dividend(s) ☐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. ☐ NONE

If You have indicated that there is no income coming into Your household, specify how YOU are being supported.

Continued:

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 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 Applicant (required) (required)

REQUIRED INCOME DOCUMENTATION iNSTRUCTIONS–Please read carefully.

PLEASE NOTE: -W-2's and IRS e-file Signature Authorization Forms (Form 8879) are not acceptable as proof of income

The following income documentation must be provided for each household family member listed in Section 4 who currently receives or has received income during the previous 12 months:

FOR NON TAXABLE INCOME	DOCUMENTATION REQUIRED
Child Support	For each child [i.e., a*pplicant, applicant's sibling(s)/step-brother(s)/step-sister(s)*] living in the family household, for whom child support is received…….Copy of most recent executed court ordered Judgment for Child Support or statement issued by CHFS, Department of Income Support, showing child support received over last 12 months.
Supplemental Security Income Benefit (SSI)	A written statement issued by Social Security Administration specifying amount received and frequency of payment
Worker's Compensation Award(s)	A written statement issued by payer of benefits (i.e., Insurance, Employer) specifying amount received and frequency of payment
Veteran's Disability Benefits	A written statement issued by the Department of Veterans Administration specifying amount received and frequency of payment
Minister/Military Cash Allowance(s)	Most recent paycheck/leave earnings statement identifying allowances. If amount not identified on paycheck/leave earnings statement, a written, signed and dated statement from employer specifying amount of allowance and frequency paid (weekly/biweekly/semi-monthly/monthly)
Retirement/ Survivors Disability Insurance (RSDI)	A written statement issued by Social Security Administration specifying amount received and frequency of payment
Damages for Physical Injury/Sickness (Excluding Black Lung)	A written statement from payer specifying amount received and frequency of payment
FOR FEDERAL TAXABLE INCOME	**DOCUMENTATION REQUIRED**
Wages, Salaries, Tips, Commissions	Last filed Federal tax return **and** most recent paycheck statement with year-to-date gross earnings information for each currently held job. If you do not have a pay statement with year-to-date gross earnings, you must provide two consecutive pay statements that specify gross amount earned and the frequency of pay **or** a written statement from your employer specifying the gross amount earned and the frequency of pay (weekly/biweekly/semi-monthly/monthly). **Note**: a copy of an electronic pay statement is acceptable.
Social Security Benefits	Last filed Federal tax return if income was reported on tax filing **or** Form SSA-1099 or Form SSA-1042S **or** a written statement issued by Social Security Administration specifying amount received and frequency of payment
Railroad Retirement Benefits	Last filed Federal tax return if income was reported on tax filing **or** Form RRB-1099 or Form RRB-1042S **or** a written statement issued by US Railroad Retirement Board specifying amount received and frequency of payment
Pension(s)	Last filed Federal tax return if income was reported on tax filing **or** Form 1099-R **or** a written statement from payer of the pension specifying amount received and frequency of payment
Unemployment Compensation	Last filed Federal tax return if income was reported on tax filing **or** Form 1099-G **or** Unemployment Income Benefit statement from State Employment Office specifying amount received and the frequency of payment
Real Estate Rentals	Last filed Federal income tax return. If income not reported on last filed income tax return or income tax return not filed: Income and Expense Report maintained by property owner for rental property for the past fiscal year
Business/Farm Income	Last filed Federal income tax return. If income not reported on last filed income tax return or income tax return not filed: Profit and Loss statement maintained by individual owning business/farm showing income and operating expenses for the past fiscal year
Partnerships	Last filed Federal income tax return. If income not reported on last filed income tax return or income tax return not filed: Profit and Loss statement maintained by partner showing income and operating expenses for the past fiscal year
S. Corporations	Last filed Federal income tax return. If income not reported on last filed income tax return or income tax return not filed: Profit and Loss statement maintained by owner showing income and operating expenses for the past fiscal year
Interest(s)/Dividend(s)	Last filed Federal income tax return. If income tax return not filed: Form 1099-DIV, Form 1099-INT or Form 1099-OID issued for the last tax year
Annuity Distribution(s)	Last filed Federal income tax return. If income tax return not filed: Form 1099-R issued for the last tax year
Estates & Trusts	Last filed Federal income tax return. If income tax return not filed: Written statement from payer specifying amount received and the frequency of payment for last tax year
IRA Distributions	Last filed Federal income tax return. If income tax return not filed: Form 1099-R issued for the last tax year
Capital & Other Gains/Losses	Last filed Federal income tax return. If income tax return not filed: Form 1099-B or Form 1099-DIV issued for the last tax year
State & Local Tax Refunds	Last filed Federal income tax return. N/A If income tax return not filed or if current household income is only from wages
Royalties	Last filed Federal income tax return. If income tax return not filed: Written statement from payer of the royalty income from oil, gas and/or mineral properties specifying amount received during the last tax year
Alimony	Last filed Federal income tax return. If income tax return not filed: Copy of most recent court executed (filed/numbered, dated and signed) divorce decree
Other (prizes, awards, jury duty, gambling winnings, etc.)	Last filed Federal income tax return. If income tax return not filed: Form 1099-MISC issued for the last tax year

Note: Submitted Tax Returns must include all schedules. Additional income documentation may be requested if needed to determine program eligibility.