Children with Special Health Care Needs Program Intake Form

Return form to: WA State Dept. of Health – NBS Program, 1610 NE 150th St. Shoreline, WA 98155 or Email: Relasha.Sampson@doh.wa.gov Phone: 206-418-5719 Fax: 206-363-1610

Child's Name (Last, First, MI)	**Date of Birth**	**Gender:** M, F or T	**Race (circle one)** Caucasian Black/African American American Indian Hispanic Pacific Islander Multi-racial Other or Unknown **Interpreter Needed? Y/N** Language:
Child's Provider One Number:			
Parent/Father/Guardian/Foster Parent			
Parent/Mother/Guardian/Foster Parent			
Address:	**City**	**Zip**	**County**
Phone number with area code:			

Agencies through which child receives services:	**Please indicate your health care insurance**:
☒ Newborn Screening Program (NBS) ☐ Women, Infants, and Children Program (WIC) ☐ Social Security Income (SSI) ☐ Developmental Disabilities Administration (DDA) ☐ Public Schools ☐ Foster Care ☐ 0-3/Family Resource Coordinator ☐ Other:_____	☐ Apple Health / Medicaid ☐ TRICARE (CHAMPUS) ☐ None ☐ Other_____ ☐ Not on Medicaid, but aware of Medicaid
Name of Child's Primary Care Doctor:	Primary Care Doctor's Phone:
Family Monthly Income _____	# of persons in household _____
Physician:	Physician Phone:
Diagnosis (mark box that applies to your child) ☐ PKU ☐ Other _____	* *Agency Use*: Indicate ICD10 Code E70:00 E71.00, E72.00 or E88.90

***Agency Use: Family meets financial eligibility to access CSHCN funds for low protein medical foods provided through the Newborn Screening program. Check the Method of determination below. Note, if does not meet eligibility based on any of the criteria below, refer family to clinic for further assistance.*

Financial Eligibility Verification

☐ Apple Health/ Medicaid
☐ WIC, or other income based programs
☐ Monthly income <210% FPL
☐ Other _____ Signature _____ Date _____

Children with Special Health Care Needs (CSHCN) Program is a state and federally funded Title V program offered through the local health jurisdiction (LHJ) in the county in which you live. The CSHCN Program provides the above information to the state for statistical purposes and coordination of care through the Health Care Authority.

☐ **I authorize this information be provided to the LHJ in _____ County where I reside and the Children with Special Health Care Needs Program.**

Signature of Parent or Guardian	**Relationship to child**	**Date**

Last updated 11/15/2017

RATIONALE and INSTRUCTIONS:

The purpose of the form is to streamline the process by which families receive CSHCN Diagnostic/Treatment funded subsidies for low protein foods. Submitting this form to the Local Health Jurisdiction (LHJ) will ensure that the child is “counted” (CHIF-ed) and will allow the LHJ to provide additional services as needed.

1) Clinic identifies child who qualifies for the low protein food subsidy. Based on the CSHCN manual, criteria are:
    a. Medical necessity – documented by checking the diagnosis box on the form
    b. Not covered by child’s health plan
    c. Financially eligible – family income <210 Federal Poverty Level (FPL) (this is the same requirement for Medicaid, so if the family is on Medicaid, they qualify). Guidelines for determining FPL are available in Section 6000 of CSHCN Manual (see link below) online.

2) Family fills out form (often with assistance from clinic) and submits to NBS/DOH

3) NBS/DOH sends the form to appropriate LHJ with cover letter and begins shipping low protein food.

4) Each year (in January), NBS/DOH sends renewal notice and form to family. It should be made clear to families that they need to renew their information each year in order to continue to receive food subsidy. Family will mail form back to NBS/DOH who will confirm financial eligibility and send notice to LHJ.

For more information see the CSHCN manual:
http://www.doh.wa.gov/Portals/1/Documents/Pubs/970-209-CSHCN-Manual.pdf)