Reset Form

CSHCS ENROLLMENT PACKET

State Form 49006 (R9 / 2-17)
Indiana State Department of Health
Children's Special Health Care Services

THIS PACKAGE CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC 3.2-10 AND 410 IAC 3.1-2-18.

* This agency is requesting disclosure of your Social Security Number in accordance with 410 IAC 3.2; disclosure is voluntary and you will not be penalized for refusal.

INSTRUCTIONS: Please print all information in blue or black ink.

County of Residence of Applicant _____ **Application Date** *(mm/dd/yyyy)* _____

Is parent/guardian/or applicant in the U.S.A. on a VISA? ☐ Yes ☐ No Is the applicant a Ward of the State? ☐ Yes ☐ No

Parent/Guardian/ or Applicant's E-mail Address: _____

Was applicant known by any other name or Nickname? ☐ Yes ☐ No _____

Primary language spoken in home: ☐ English ☐ Spanish ☐ Other _____

CSHCS USE ONLY: Effective Date *(mm/dd/yyyy)*: _____ **CSHCS Key Number:** _____

Applicant's Name _____ Date of Birth *(mm/dd/yyyy)*: _____
Last First MI

Medical Condition applicant has: _____

Social Security Number* _____ ☐ M ☐ F Race _____ Ethnicity _____

Current Address *(number and street)* _____

City _____ ZIP code _____

Home telephone ( ) _____ Work telephone ( ) _____

Parent/Guardian _____

Current Address *(number and street)* _____

City _____ ZIP code _____

Home telephone ( ) _____ Alternate telephone ( ) _____

Work telephone ( ) _____

Parent/Guardian _____

Current Address *(number and street)* _____

City _____ ZIP code _____

Home telephone ( ) _____ Alternate telephone ( ) _____

Work telephone ( ) _____

***Personnel Other Than Parent/Guardian/Applicant completing application:** _____

Agency: _____

Address *(number and street)* _____

City: _____ State: _____ ZIP Code: _____

Telephone: ( ) _____ Fax: ( ) _____

*HIPAA FORM ON PAGE 11 COMPLETED AND ATTACHED: ☐ YES ☐ NO

HOUSEHOLD MEMBERS AND INCOME INFORMATION

Part of State Form 49006 (R9 / 2-17)

* This agency is requesting disclosure of your Social Security Number in accordance with 410 IAC 3.2; disclosure is voluntary and you will not be penalized for refusal.

List all persons (including participant) who live in your home and provide requested information for each individual. This includes children who are in college. *Use additional paper if necessary.*

Name	Relationship to applicant	Date of Birth *(mm/dd/yyyy)*	Gender	Race	Ethnicity	Social Security Number*	Date applied for HHW or Medicaid *(mm/dd/yyyy)*	Other Insurance Y/N

CSHCS Household Size: _____

Income verification must be provided for everyone receiving income that is part of the household (e.g. related or not related). Include copies of all documentation used to prove income. Preferred documentation is the most recent three (3) consecutive paycheck stubs for all household members. Other acceptable documentation is an employer's letter (on company letterhead) signed and dated, showing how much you earn and how often received. If you are self-employed and have other income that is not reflected on your paycheck stubs, you must provide a copy of all household members' latest federal tax form 1040 or other documents that can verify income. Additional documentation may be requested.

	1		2		3	
NAME OF PERSON RECEIVING INCOME →→→→→ *Use additional paper if necessary.*						
Wages/Fees/Commissions/Tips/Sick Benefits	Gross Amount	How Often	Gross Amount	How Often	Gross Amount	How Often
Social Security or SSD or SSI						
Dividends/Interest on Savings						
Unemployment Compensation/Strike Benefits						
Alimony/Child Support/TANF *(provide documentation)*						
Regular Contributions from persons not living in the household *(provide name, signed statement & amount)*						
Other income not listed above includes: Trustee Assistance, Farm Income, Rental Income, Pensions, Annuities, Trusts, Royalties, Estates, Military Compensation, and Adoption Subsidy						

If you have no income, how do you pay your bills? *(supply written and signed statements)* _____

_____

CSHCS USE ONLY: Total Household Income $ _____

_____ Date *(mm/dd/yyyy)*: _____

(Signature of Agency or CSHCS Personnel)

MEDICAL INSURANCE INFORMATION

Part of State Form 49006 (R9 / 2-17)

Complete a <u>new</u> form for each insurance coverage.

1. APPLICANT IDENTIFYING INFORMATION:

Name: _____ Date of Birth *(mm/dd/yyyy)*: _____ CSHCS Number: _____

Address: _____ _____ IN _____

Street City ZIP Code

2. HOOSIER HEALTHWISE or MEDICAID (age appropriate) NUMBER: _____

Complete One:

Current Coverage Effective Date *(mm/dd/yyyy)*: _____

Pending HHW Date/or Date application was mailed *(mm/dd/yyyy)*: _____

Not Financially Eligible Date of Denial *(mm/dd/yyyy)*: _____

Medicaid Disability with/without spend down $_____ ***(if known)***

3. POLICYHOLDER INFORMATION:

Name: _____ Relationship: _____ Telephone: ( ) _____

Address: _____

Street City State ZIP Code

4. INSURANCE COMPANY INFORMATION: ☐ **Primary** ☐ **Secondary**

Name: _____ Telephone: ( ) _____

Billing Address: _____

Street City State ZIP Code

Check As Applicable: Is this Coverage: ☐ Through Employer ☐ Self Purchase ☐ Union ☐ HMO Policy ☐ PPO Policy

5. POLICY NUMBER: _____ Member/I.D. Number: _____ Group/Account Number: _____

Effective date dependent will be covered under policy *(mm/dd/yyyy)*: _____ Termination Date *(mm/dd/yyyy)*: _____

6. EMPLOYER INFORMATION:

Name of Employer: _____

Address: _____

Street City State ZIP Code

Telephone: ( ) _____ Start Date *(mm/dd/yyyy)*: _____

7. COVERAGE INFORMATION: *Check As Applicable:*

A. Second Insurance Company Coverage? ☐ YES ☐ NO

B. Therapy Services Covered: ☐ OT ☐ PT ☐ Speech

C. Co-Payments? ☐ YES ☐ NO

Office Visit Amount: $ _____ Specialist Amount: $ _____

Emergency Room Amount: $ _____ Other Amount: $ _____

Prescriptions Amount: $ _____ DME Services Amount: $ _____

D. Deductibles? ☐ YES ☐ NO If YES, Amount: $ _____

E. Maximum Out of Pocket Expense $ _____

F. Is there a pre-existing clause? ☐ YES ☐ NO

Effective Date *(mm/dd/yyyy)*: _____

G. Is there a dental plan? ☐ YES ☐ NO

Name of plan if different: _____

Effective Date *(mm/dd/yyyy)*: _____

Termination Date *(mm/dd/yyyy)*: _____

H. Lifetime maximum? ☐ YES ☐ NO

$ _____ per person $ _____ per family

I. Conditions/Exclusions: _____

PROVIDER HISTORY INFORMATION

Part of State Form 49006 (R9 / 2-17)

Applicant's Name _____ Date of Birth *(mm/dd/yyyy)*: _____

Health care received in the past twelve (12) months (*copy additional pages of this section as needed*). List the primary care physician for all well-child care including immunizations and illness. List the dentist (*if applicable*), clinics and other medical care providers by specialty type.

Name of Primary Care Physician:	Group Name:
Address *(number and street)*: City, State, ZIP code:	Telephone: ( ) Fax: ( )
Reason(s) Seen**:**	Date Last Seen *(mm/dd/yyyy)*:
Name of Dentist:	Group Name:
Address *(number and street)*: City, State, ZIP code:	Telephone: ( ) Fax: ( )
Reason(s) Seen**:**	Date Last Seen *(mm/dd/yyyy)*:
Name of Specialty Care Physician:	Group Name:
Address *(number and street)*: City, State, ZIP code:	Telephone: ( ) Fax: ( )
Reason(s) Seen**:**	Date Last Seen *(mm/dd/yyyy)*:
Other Specialty Provider:	Group Name/Hospital/ER:
Address *(number and street)*: City, State, ZIP code:	Telephone: ( ) Fax: ( )
Reason(s) Seen**:**	Date Last Seen *(mm/dd/yyyy)*:
Other Specialty Provider:	Group Name/Hospital/ER:
Address *(number and street)*: City, State, ZIP code:	Telephone: ( ) Fax: ( )
Reason(s) Seen**:**	Date Last Seen *(mm/dd/yyyy)*:

MEDICINES and MEDICAL EQUIPMENT

Part of State Form 49006 (R9 / 2-17)

What type(s) of adaptive equipment is currently used by your child? (✓ accordingly)

☐ Wheelchair ☐ Walker ☐ Splints/AFO's (ankle, foot, orthosis) ☐ Eye Glasses
☐ Adaptive seating ☐ Adaptive bathing ☐ Assistive Communication Device(s) ☐ Braces
☐ Feeding Aids ☐ Hearing Aids ☐ Other:_____

What medical, health equipment or supplies are routinely used by applicant? (✓ accordingly)

☐ Apnea Monitor ☐ Oxygen ☐ Prescription Drugs ☐ Tube Fed
☐ Ventilator Dependent ☐ Other:_____

Current Medications ***(specify dose, frequency and purpose)***

Medication	Dosage	Frequency	Purpose

Is the applicant currently on a special diet? ☐ YES ☐ NO Type: _____

Additional Comments: _____

_____

_____

_____

APPLICATION FOR ENROLLMENT
CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS)
Part of State Form 49006 (R9 / 2-17)

INSTRUCTIONS FOR COMPLETING THIS FORM:

1. Applicant/Parent/Guardian must sign all copies in ink.
2. Once completed and signed, an application shall never be altered by the applicant or by an employee or designee of the State Department, County, or Family and Social Services Administration. No application shall be destroyed unless proper legal procedures are followed. Send application to CSHCS at the address listed on the Check List Page 3.

PARTICIPANT RIGHTS INCLUDE:

1. Fair treatment regardless of race, color, creed, national origin, age, gender, or disability.
2. An administrative hearing may be requested. Any decision affecting your participation in CSHCS, which you do not agree with, can be reviewed. You must request a hearing within eighteen (18) days from the day of notice of the decision. You shall do this in writing. More information on the hearing process will be given to you, in writing, at the time the decision is made.

STATEMENT OF AGREEMENT:

In support of this application, I will, when requested, supply such information as I can to persons authorized to request and receive it.

I hereby certify, under penalty of perjury, that all of the information, including the verified income is complete and correct to the best of my knowledge.

I hereby give consent for routine health care, diagnostic evaluation and medical treatment under Children's Special Health Care Services and/or Maternal and Child Health Services. I understand that I must use all available health insurance and/or Medicaid coverage for the child's healthcare before the Indiana State Department of Health makes any payments. In the event that the insurance payment is made directly to my spouse or me, I will pay said payment to the Indiana State Department of Health as a repayment for costs paid by the Department.

I understand that the availability of and the provision of health care services included in the basic service component and the limited service component is contingent upon the availability of program funding.

I hereby consent to the release of personal and financial record information on this form to the Indiana State Department of Health for the purposes of verifying eligibility and performing program evaluations.

I, being the applicant (parent or legal guardian) understand the application date for enrollment in the Children's Special Health Care Services Program will be the date of this signature as long as I provide the financial and social information necessary to complete this application, within the thirty (30) days, to the CSHCS Program Designee (interviewer completing this application). **I understand that if I do NOT provide this information, this application will be denied for failure to cooperate in the application process.** I understand that I will be required to initiate a new application with updated information and sign a new signature page if I want to go forward with the application process. The new signature date will become the date of the application and the effective date will be adjusted accordingly.

I understand that the approved health and welfare agencies of the Indiana State Department of Health will maintain confidentiality of this information pursuant to IC 16-39, IC 5-14-3-4(a)(9), 42 CFR§51a, 112, and 7CFR§246.26(d).

_____
Applicant's Name *(*May sign for self if over eighteen (18) years of age or older)*

Signature of Applicant/Parent/Legal Guardian	Relationship to Applicant	Date *(mm/dd/yyyy)*
Signature of Applicant/Parent/Legal Guardian	Relationship to Applicant	Date *(mm/dd/yyyy)*
Signature of Agency Personnel		Date *(mm/dd/yyyy)*

AUTHORIZATION FOR THE COLLECTION OF INFORMATION
CHILDREN'S SPECIAL HEALTH CARE SERVICES
Part of State Form 49006 (R9 / 2-17)

PLEASE REVIEW THE FOLLOWING INFORMATION AND HAVE YOUR INTAKE or SERVICE COORDINATOR DISCUSS ANY QUESTIONS THAT YOU MAY HAVE BEFORE SIGNING BELOW.

Applicant's Name: _____ Date of Birth *(mm/dd/yyyy)*: _____

We are asking for your permission as parent/legal guardian/emancipated minor/person eighteen (18) years of age or older, to collect demographic and service information about you and/or your child and store it electronically in the Indiana State Department of Health (ISDH) and/or Family and Social Services Administration (FSSA) database system(s).

The program you are enrolling in is the Children's Special Health Care Services, a program that provides the primary, specialty, diagnostic and dental-related care for medically and financially eligible children 0-21 years of age. Services available through this program include screening, evaluation and assessment, service coordination, due process and procedural safeguards, health and medical services that are made available based upon the needs of the child and family.

This authorization covers certain medical ("Protected Health Information"), social and financial information about the eligible child and family, unless an exception is noted below, including: child/family demographic information; health visit information; infant/child visit data; disability/risk factors; problems or factors that prevent the eligible child and family from receiving appropriate services or medical care; appointments made and services received; Individualized Family Service Plan (IFSP) activities, care plans and family financial eligibility information.

Based upon the information collected during the eligibility determination and enrollment process, a multidisciplinary team will work with you to determine your child's needs for services. With your informed, written authorization, only those health care professionals and service providers with a direct need to know and with authorized security clearance will have access to the electronic file or authorizations for eligibility determination services that are required and authorized by you as your child's parent/legal guardian. Statistical and program information, without any child or family identifying information, will be sent to State and Federal agencies that fund these services to meet various reporting requirements.

Individually designated and signed releases are maintained in your child's record at the local System Point of Entry/ISDH/MCH clinics that indicate individuals with whom you have given your informed, written authorization for reciprocal communications including the sharing and receipt of reports. The person(s) receiving this information has a legal and ethical duty to keep the information in a confidential and private manner, and will not release it to anyone else without your written permission unless allowed by law.

By signing this authorization form, you agree to allow information to be collected through the System Point of Entry or state intake personnel for the electronic database collection systems. All aspects of the data collection, maintenance and utilization are protected under the Family Education Rights and Privacy Act (FERPA). All personal information collected will be treated as confidential pursuant to IC 4-1-6 et seq., IC 5-14-3-4 and 410 IAC 3.2-10, 42 CFR §51a. As the parent/legal guardian, access to information stored in the database is also available to you upon request for inspection or copying. As legal guardian, you authorize the ISDH and/or FSSA database system(s) to distribute information collected during the eligibility determination/enrollment process and service delivery period to the following:

1. Indiana Family and Social Services Administration, the Division of Disability and Rehabilitative Services, First Steps, and Hoosier Healthwise
2. Indiana Department of Education
3. Indiana State Department of Health
4. U.S. Departments of Education, and Health and Human Services, for the purposes of financial/program audit and monitoring purposes as required by various federal and state regulations.

By signing this authorization, I acknowledge that I have read and understand the information for collection and sharing of data contained on the forms. The authorization will remain in effect no longer than twelve (12) months from the date of my signature. **I understand that I have the right to revoke this authorization, if the revocation is in writing, except to the extent that action has been taken in reliance on this authorization.**

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient as required by applicable law and the privacy of my Protected Health Information may no longer be protected by HIPAA.

_____ _____

Signature of parent/legal guardian/applicant *(if eighteen (18)+ or an emancipated minor)* Date *(mm/dd/yyyy)*

_____ _____

Signature of Agency Personnel Date *(mm/dd/yyyy)*

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
CHILDREN'S SPECIAL HEALTH CARE SERVICES
Part of State Form 49006 (R9 / 2-17)

* This agency is requesting disclosure of your Social Security Number in accordance with 410 IAC 3.2; disclosure is voluntary and you will not be penalized for refusal.

I hereby authorize the Children's Special Health Care Services program of the Indiana State Department of Health and any of its employees and agents, to disclose confidential information about the applicant identified below.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.

1. Applicant Information

Last Name	First Name	Middle Initial
Last Four Digits of Social Security Number *	Birth Date *(mm/dd/yyyy)*	Daytime Telephone Number (*include area code)*
Street Address *(number and street)*	City, State and ZIP Code	

2. I authorize the entity(ies) and its agents identified below to receive confidential health information pertaining to the applicant above.

Entity authorized to receive confidential information	Daytime Telephone Number (*include area code)*
Street Address *(number and street)*	City, State and ZIP Code
Entity authorized to receive confidential information	Daytime Telephone Number (*include area code)*
Street Address *(number and street)*	City, State and ZIP Code
Entity authorized to receive confidential information	Daytime Telephone Number (*include area code)*
Street Address *(number and street)*	City, State and ZIP Code

3. Purpose of this Authorization *(check all that apply)*

☐ This authorization is for the purpose of processing the application and accompanying documents and records to determine the Applicant's eligibility for the Children's Special Health Care Services program of the Indiana State Department of Health and authorizes communication between said program's employees and agents and the entity(ies) named in section 2 above.

☐ This authorization is only for requests for the following specific information:

_____

_____

_____

_____

If this authorization is limited to information in effect for a specific period of time, please indicate:

_____ **through** _____

mm/dd/yyyy *mm/dd/yyyy*

4. Description of the information to be released or disclosed: (*check all that are appropriate*)

☐ Application or enrollment information.
☐ Other: (*please specify*)

_____
_____
_____

5. IMPORTANT: Your signature below means that you understand and agree to the following:

- The protected health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, and/or communicable diseases, including HIV/AIDS. These records will be included in the information we will make available to the entity(ies) identified in Section 2 above.
- Information disclosed under this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations.
- Your eligibility for benefits and payment for services will not be affected if you do not sign this form. (However, without your signature, we will not be able to communicate with the entity(ies) identified in Section 2 for the purposes of processing your application.)
- This authorization will expire after the eligibility status of the Applicant has been determined or one year from the date you sign this authorization, whichever event occurs first. If you sign this form, you may revoke the authorization at any time by notifying the Children's Special Health Care Services of the Indiana State Department of Health in writing at the address below. Revoking this authorization will not affect any actions that took place in reliance on the authorization before we received notification.

6. Signature of Applicant's Parent or Legal Representative

Signature of Applicant's Parent *(if Applicant is an unemancipated minor child)*, or Applicant's Legal Representative	Date *(mm/dd/yyyy)*
Print Name	
Describe the relationship to the Applicant: ☐ Natural or Adoptive Parent of Unemancipated Minor Child ☐ Legal Representative (i.e. someone with authority to act on the Applicant's behalf)	

Return this completed form with the Application to:

Indiana State Department of Health
Children's Special Health Care Services
Section 5C
2 North Meridian Street
Indianapolis, Indiana 46204

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE.

AUTHORIZATION TO RELEASE AND SHARE MEDICAL INFORMATION
CHILDREN'S SPECIAL HEALTH CARE SERVICES
Part of State Form 49006 (R9 / 2-17)

PLEASE REVIEW THE INFORMATION ON THE REVERSE SIDE OF THIS FORM, AND HAVE YOUR INTAKE/SERVICE COORDINATOR DISCUSS ANY QUESTIONS THAT YOU MAY HAVE BEFORE SIGNING BELOW.

I/We, _____ hereby authorize:
Applicant/Parent/Legal Guardian Name(s)

_____
Physician/Health/Medical Care Provider or Facility Name

_____
Practice/Hospital *(as applicable)*

_____
Street Address/Post Office

_____
City/Town State ZIP Code

To communicate and to share information including medical ("Protected Health Information"), in writing and conversation, with the First Steps Early Intervention Service System and Children's Special Health Care Services regarding:

_____
Applicant's Legal Name Date of Birth *(mm/dd/yyyy)*

_____
Street Address/Post Office

_____
City/Town State ZIP Code

This authorization includes the following types of information *(as checked ✓)*:

☐ Medical record information including but not limited to: progress notes, laboratory and x-ray reports, history and physical, discharge summary and treatment plan(s)

☐ Written specialty reports including assessments

☐ Medical record information required to determine eligibility, participate in service planning, and/or provide early intervention services as defined in the Individualized Family Service Plan (IFSP)

I HAVE READ AND UNDERSTAND THE CONDITIONS OF THIS RELEASE, AS CONTAINED ON THE REVERSE SIDE OF THIS FORM.

_____ _____
Signature *(Applicant if over eighteen (18) years of age)* Date *(mm/dd/yyyy)*

_____ _____
Signature *(Parent/Legal Guardian)* Date *(mm/dd/yyyy)*

_____ _____
Signature of Agency Personnel Date *(mm/dd/yyyy)*

- OVER -

AUTHORIZATION TO RELEASE AND SHARE MEDICAL INFORMATION
CHILDREN'S SPECIAL HEALTH CARE SERVICES
Part of State Form 49006 (R9 / 2-17)

INSTRUCTIONS: Please read this carefully before signing. If you have questions, please ask your service coordinator care coordinator (if applicable)

The purpose of this release is to collect information necessary to determine the participant's eligibility for the programs listed above, and to plan and provide essential and necessary services as determined through the multidisciplinary team process. I hereby authorize the medical provider named on this form to release to the staff of Maternal and Child Health Services, and/or Hoosier Healthwise, and/or First Steps and/or Children's Special Health Care Services upon presentation of this form, any records or information pertinent to the development and implementation of a plan for service to meet the medical, educational, developmental, social, and rehabilitative needs for the participant named on this form. Authorization is also granted for release of information by Maternal and Child Health Services, and/or Hoosier Healthwise, and/or First Steps and/or Children's Special Health Care Services to accomplish referrals for service to other individuals where an informed, written consent has been obtained from me as the parent/legal guardian; and to ensure ongoing service delivery in accordance with the IFSP through routine communications including report distribution, participation in IFSP meetings, and planning and review activities.

I understand that this consent includes the sharing of information as authorized above in written, verbal, and/or video format. As the parent/legal guardian, or surrogate parent (for educational purposes only, in the event one is appointed for early intervention services), I understand that I may revoke this authorization shown on the reverse of this form at any time in writing. The request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first. A copy of this "Authorization to Release and Share Medical Information" has the same effect as an original.

The information collected as a result of this consent shall be maintained in the participant's record which will be located at Maternal and Child Health Services, and/or the Indiana Hoosier Healthwise, and/or First Steps, and/or Children's Special Health Care Services. This record is subject to the provisions of the Family Educational Rights and Privacy Act (FERPA) and Release of Medical Records Law IC 16-39, as such, is available for my review and may be reproduced or corrected upon my request. All personal information collected will be treated as confidential pursuant to IC 4-1-6 et seq., IC 5-14-3-4 and 410 IAC 3.2-10.

PHYSICIAN'S HEALTH SUMMARY
CHILDREN'S SPECIAL HEALTH CARE SERVICES
Part of State Form 49006 (R9 / 2-17)

INSTRUCTIONS: Your patient is currently in the evaluation process for eligibility for CSHCS and/or early intervention services under Part C of the Individuals with Disabilities Education Act (IDEA). All components of this evaluation are required to be completed within forty-five (45) days. The health summary request is an initial step in this process. Your participation in the evaluation to determine the child's eligibility is requested by completing and returning this form in the enclosed envelope. If you have questions, please contact the Intake/Service Coordinator listed on the cover letter. Your participation in this activity is greatly appreciated.

IDENTIFYING INFORMATION

Applicant's Name: _____ Date of Birth *(mm/dd/yyyy)*: _____

Parent/Guardian: _____

MEDICAL INFORMATION

Birth Place: _____ Birth Weight: _____ (grams) _____ (lbs/oz) Apgar _____ Gestational Age: _____

Length of Hospital Stay: _____ Past Hospitalizations/Illnesses: _____

_____

***ADDITIONAL COMMENTS (please include any recommendations you may have)*:** _____

_____

CURRENT HEALTH STATUS

Present diagnosis/illnesses including ICD/DSM CODE(S): _____

_____

Current Medications and frequency : _____

_____

Medical Precautions: _____

Immunization Information:

DPT/DTaP _____ _____ _____ _____ DT _____ _____ TB _____ _____ Varicella _____

IPV/OPV _____ _____ _____ MMR _____ or Measles _____ Mumps _____

Hep B _____ _____ _____ Hib _____ _____ _____ _____ Rubella _____

Physical Status: _____

Vision: _____ Hearing: _____

Date Screened/Tested *(mm/dd/yyyy)*: _____ Date Screened/Tested *(mm/dd/yyyy)*: _____

Developmental Screening: Date *(mm/dd/yyyy)*: _____ Results: _____

Date Last Seen *(mm/dd/yyyy)*: _____ Other Physician Referrals Made: _____

If indicated, I authorize the above named child to be seen as follows:

_____ Physical therapy evaluation, as indicated

_____ Occupational therapy evaluation, as indicated

_____ Speech therapy evaluation, as indicated

_____ _____

Physician's Signature *(Primary/Specialty Health Provider)* Date *(mm/dd/yyyy)*

_____

Physician's Name *(Please Print)*

_____

Physician's Address/Telephone Number

Return to: **ISDH/CSHCS**
2 N Meridian St., Section 5C
Indianapolis, IN 46204

Telephone: 1-800-475-1355
Fax: 317-233-1342