



## CSHCS ENROLLMENT PACKET

State Form 49006 (R5 / 1-11)

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

*INSTRUCTION: If you have questions, please call 1-800-475-1355 Eligibility Option and ask for Training Coordinator.*

Children's Special Health Care Services Enrollment Packet consists of fifteen (15) pages. Please **print** all information except where signatures are required. The program serves Indiana residents age 0-21 years of age. Applicants with Cystic Fibrosis can apply to this program **at any age**, but must be financially eligible.

Remember the **Application Date** must be on all pages where a date is required. Exception – page 13 should be the current date because this form is only good for sixty (60) days. **The completed enrollment packet must be submitted to CSHCS within thirty (30) days of the application date.**

**Page 3: Enrollment Form Checklist.** This checklist will help to ensure that you are submitting all necessary documents. **If you are sending this application for a diagnostic, the family must be financially eligible for CSHCS and must be testing for an eligible medical condition.** If family refuses to cooperate or does not return requested documentation, application is to be submitted for denial and appropriate reason checked.

**Page 4: Applicant and parent/guardian information.** The **Application Date** is the date you are completing the form. The CSHCS Key Number and Effective Date will be completed by ISDH staff. The remainder of the form is self-explanatory. There are some exceptions:

- a) only a parent (regardless of age) or legal guardian can sign this application, so if the applicant is a Ward of the County/State, the caseworker's information goes on the first line for parent/guardian and the foster parent's information can go on the second line;
- b) a surrogate parent (First Steps), a step-parent who has not legally adopted the applicant, or a Foster Parent cannot sign this application.

***We need to know the medical condition for which an applicant is applying to CSHCS.*** This can be exactly what the doctor has told you and/or the parent. If this application is being completed by someone other than the parent, please sign and complete the requested information.

**Page 5: Household Members and Income Information.** List all persons living in the household **regardless if related or not** (i.e. mom, child & mom's boyfriend). We will count the boyfriend's or any other working household member's income. A pregnant woman is considered one (1) person. We do not count the child until it is born. There are no special codes to use, just put m=mom, d=dad, o=other, b=brother, a=applicant, etc. There are some exceptions, so if you have an unusual situation, please call, as they are too numerous to list. Complete information across the table and for Other Insurance, put Y or N.

The CSHCS program counts **ALL** income for the household and we use GROSS income. The CSHCS program requires that Income documentation be submitted with the application and the **preferred documentation** is latest Federal 1040 that was filed. If parent/guardian/applicant states they have no income, ask, document and request written and signed statements on how rent is paid, food is bought, and utilities are paid. If this application is being completed by someone other than the parent/guardian/applicant, please sign the bottom of Income page; otherwise, CSHCS personnel will sign this page.

**Page 6: Medical Insurance Information.** Complete boxes 1 and 2 always. Boxes 3-7 should be completed only if there is private insurance.

**Page 7: Provider History Information.** Complete as thoroughly as possible.

**Page 8: Medicines and Medical Equipment.** Complete as thoroughly as possible.

**Page 9: Application for Enrollment form.** - Read, sign, and date.

**Page 10: Authorization for the Collection of Information.** – Read, sign, and date.

**Page 11: Authorization for the Release of Protected Health Information.** – This form allows CSHCS to exchange information with person/entity helping parent/guardian/applicant complete the application. If no one is helping parent/guardian/applicant complete this application, the form does not need to be filled out.

**Page 13: Authorization to Release and Share Medical Information.** – REMEMBER: put **current date** on this form. Complete one for each provider that can verify medical diagnoses. *If the medical is less than one (1) year old and can be submitted with the application, there is no need to send this form to any provider. However, the form must be completed and submitted with the application.*

This form may be copied to accommodate additional providers. When sending to more than one provider, remember to copy the back of the form. **A copy or copies of the completed form must be submitted with the application.**

**Page 15: Physician's Health Summary Form.** - This page is to be mailed or given, along with the Authorization to Release & Share Medical Information form, to the provider or providers who can verify medical diagnoses. If the medical is being submitted with the application there is no need to mail the form; however, it should be sent with the application.

**Additional Forms: Hoosier Healthwise/Medicaid: If the applicant is not on Hoosier Healthwise/Medicaid, this form needs to be completed. The parent/guardian or applicant can call 1-800-403-0864, option 2 for instructions on where to mail this form. Please copy the HHW form and submit the copy with the CSHCS application.**

**If applicant is age nineteen (19) or older, they must apply for the most appropriate Medicaid program and supply proof of submitted application and completion of eligibility process.**

**NOTE: If you have any questions, please call 1-800-475-1355, Eligibility Option and ask to speak with the Training Coordinator. The direct number is 317-233-5571.**

**ENROLLMENT CHECKLIST**

Part of State Form 49006 (R5 / 1-11)

Applicant's Name \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_\_

**APPLICATION IS FOR DIAGNOSTICS TESTING (applicant is financial eligible for CSHCS and the test is for an eligible medical condition)**

Income page signed, income documentation attached

Hoosier HealthWise (HHW)/Medicaid: Submit documentation that applicant either has HHW or has applied. **(THIS IS A MANDATORY REQUIREMENT OF THE CSHCS PROGRAM.)**  
**The CSHCS application may be submitted while applicant is awaiting a HHW decision.**

Medical Insurance Information page completed (if applicable), signed and dated, copy of either HHW card or insurance card (front and back) attached

Authorization for the Collection of Information form signed and dated

Authorization for the Release of Protected Health Information form signed and dated (if applicable)

Application for Enrollment with CSHCS page signed and dated

Copy(ies) of Authorization to Release & Share Medical information completed, signed and dated attached **(Original(s) are to be sent to medical provider to verify diagnosis.)**  
**Separate form for each medical provider to be contacted.**

**APPLICATION IS RECOMMENDED FOR DENIAL**  
**(If the application has been signed by the parent/legal guardian/applicant, it must be submitted.)**

Voluntary withdrawal of application  
*(requires written confirmation from parent/guardian/applicant)*

Applicant is over age twenty-one (21)

Failure to apply for Medicaid/HHW

Failure to complete application process

Failure to disclose income

Family is financially ineligible

Other: \_\_\_\_\_

**Please mail application and all documentation within thirty (30) days of Application date to:**

Children's Special Health Care Services (CSHCS)  
**ATTN: Eligibility Section**  
Indiana State Department of Health  
2 North Meridian St., Section 7-B  
Indianapolis, IN 46204

**CSHCS application may be submitted while applicant is awaiting a HHW decision.**



**HOUSEHOLD MEMBERS AND INCOME INFORMATION**

Part of State Form 49006 (R5 / 1-11)

\* 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 your household. Include copies of all documentation used to prove income. Preferred documentation is the most recent 1040 Federal tax form; however, if income has changed from last 1040 report, still provide the 1040, but also provide your three (3) most recent consecutive check stubs and write a note of explanation. Other acceptable documentation is an Employer's letter (on company Letterhead) signed and dated, showing how much you earn and how often received. Attach additional sheet if necessary.

	1		2		3	
<b>NAME OF PERSON RECEIVING INCOME →→→→→</b> <i>Use additional paper if necessary.</i>						
	Gross Amount	How Often	Gross Amount	How Often	Gross Amount	How Often
Wages/Fees/Commissions/Tips/Sick Benefits						
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, and Military Compensation						

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 (R5 / 1-11)

Complete a new form for each insurance coverage.

<b>1. APPLICANT IDENTIFYING INFORMATION:</b>	
Name: _____ Date of Birth (mm/dd/yyyy): _____ CSHCS Number: _____	
Address: _____ IN _____	
Street	City
Street	City
<b>2. HOOSIER HEALTHWISE or MEDICAID (age appropriate) NUMBER:</b>	
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)	
<b>3. POLICYHOLDER INFORMATION:</b>	
Name: _____ Relationship: _____ Telephone: ( ) _____	
Address: _____	
Street	City
Street	City
State	ZIP Code
<b>4. INSURANCE COMPANY INFORMATION:</b> <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	
Name: _____ Telephone: ( ) _____	
Billing Address: _____	
Street	City
Street	City
State	ZIP Code
Check As Applicable: Is this Coverage: <input type="checkbox"/> Through Employer <input type="checkbox"/> Self Purchase <input type="checkbox"/> Union <input type="checkbox"/> HMO Policy <input type="checkbox"/> PPO Policy	
<b>5. POLICY NUMBER:</b> _____ Member/I.D. Number: _____ Group/Account Number: _____	
Effective date dependent will be covered under policy (mm/dd/yyyy): _____ Termination Date (mm/dd/yyyy): _____	
<b>6. EMPLOYER INFORMATION:</b>	
Name of Employer: _____	
Address: _____	
Street	City
Street	City
State	ZIP Code
Telephone: ( ) _____ Start Date (mm/dd/yyyy): _____	
<b>7. COVERAGE INFORMATION:</b> <i>Check As Applicable:</i>	
A. Second Insurance Company Coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO	F. Is there a pre-existing clause? <input type="checkbox"/> YES <input type="checkbox"/> NO
B. Therapy Services Covered: <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech	Effective Date (mm/dd/yyyy): _____
C. Co-Payments? <input type="checkbox"/> YES <input type="checkbox"/> NO	G. Is there a dental plan? <input type="checkbox"/> YES <input type="checkbox"/> NO
Office Visit Amount: \$ _____ Specialist Amount: \$ _____	Name of plan if different: _____
Emergency Room Amount: \$ _____ Other Amount: \$ _____	Effective Date (mm/dd/yyyy): _____
Prescriptions Amount: \$ _____ DME Services Amount: \$ _____	Termination Date (mm/dd/yyyy): _____
D. Deductibles? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, Amount: \$ _____	H. Lifetime maximum? <input type="checkbox"/> YES <input type="checkbox"/> NO
E. Maximum Out of Pocket Expense \$ _____	\$ _____ per person \$ _____ per family
	I. Conditions/Exclusions: _____

**PROVIDER HISTORY INFORMATION**

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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.

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



**APPLICATION FOR ENROLLMENT  
CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS)**

Part of State Form 49006 (R5 / 1-11)

**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 (R5 / 1-11)

**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, Aging and Rehabilitation 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 (R5 / 1-11)

\* 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)

<input type="checkbox"/> Application or enrollment information. <input type="checkbox"/> 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:	
<input type="checkbox"/> Natural or Adoptive Parent of Unemancipated Minor Child	
<input type="checkbox"/> 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 7B  
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 (R5 / 1-11)

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 (R5 / 1-11)

*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 (R5 / 1-11)

*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 7B  
Indianapolis, IN 46204**

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