Please send completed application to:
CSHSClinicalServices@la.gov

LOUISIANA DEPARTMENT OF HEALTH

Date received by CSHS office:
_____

Application for Children's Special Healthcare Services – Clinical Services (CSHS-CS)

SECTION 1: APPLICANT & HOUSEHOLD INFORMATION

1. Tell us about the patient applying to Children's Special Healthcare Services - Clinical Services (CSHS-CS).

Name (First, MI, Last): _____

Date of Birth (month/date/year): _____ Sex: ☐ Male ☐ Female ☐ Unknown

Mailing address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Phone Number: _____ Alternate Phone Number: _____

Louisiana Resident: ☐ Yes ☐No (please explain): _____

Social Security Number: _____ Preferred Language: _____

Ethnicity: ☐ Hispanic ☐Non-Hispanic ☐ Choose Not to Reply

Race: ☐ American Indian/Alaskan Native ☐ Black/African American ☐ Asian ☐ White
☐Native Hawaiian/Pacific Islander ☐More Than One Race ☐ Choose Not to Reply

2. Tell us about the patient's parent/guardian (if under age 18).

Name (First, MI, Last): _____

Relationship to Patient: _____ Preferred Method of Contact: ☐ Phone ☐ Email

Please list the following information if different from patient's above:

Home address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Phone Number: _____

3. How many people live in the patient's household? _____

SECTION 2: FINCANCIAL & INSURANCE INFORMATION

4. Check all the benefits the patient currently receives from the list below:

☐ Medicaid/Healthy Louisiana ☐ Medicare ☐LaCHIP ☐Tricare (military) ☐ Private Insurance ☐ No Insurance

5. ONLY patients that DO NOT have Medicaid/Healthy Louisiana or LaCHIP must answer this question. Additional paperwork will be required to determine eligibility.

What is the total monthly income for all household members? $_____

This includes income from work and any of the following:

Child Support	Social Security	Workman's Compensation	Interest/Dividends/Royalties	Refugee Cash Assistance
Alimony	Veteran's Benefits	Military Family Allotment	Retirement/Pension/Annuities	Other Sources of Income

SECTION 3: DISABILITY & HEALTH CARE INFORMATION

6. What is the patient's diagnosis or disability?

_____

7. Please tell us about the doctors who have provided care for the patient over the last 2 years:

Specialty	Doctor's Name	Doctor's Phone Number
Primary Care Provider		

8. Has the patient ever received any services from a parish public health unit in Louisiana?

☐ No ☐ Yes If yes, enter parish name: _____

SECTION 4: EMERGENCY CONTACT INFORMATION

9. List the contact information for 1-2 close friends or relatives in case the parent/guardian cannot be reached in an emergency.

Name	Relationship to Patient	Phone Number

SECTION 5: DIAGNOSIS CONFIRMATION (to be signed by doctor)

Please have the patient's doctor submit confirmation of their suspected diagnosis or health condition. It must be sent along with this form in ONE of the following ways. The doctor may:

- Complete this section of the form.
- Email, mail, or fax a medical note that includes the information below (use the contact information at the top of this application to submit).

Diagnosis/Health Condition: _____

Signature/Credentials (doctor): _____ Date: _____

SIGNATURE

By signing below, I confirm that I am applying for Children's Special Healthcare Services – Clinical Services for assistance for the patient named in Question 1. The information I have given on this application is true to the best of my knowledge. I grant permission for Children's Special Healthcare Services – Clinical Services to obtain information needed to verify the patient's medical and financial situation.

_____ _____

Signature of Patient, Legal Guardian or Agency Representative
(include title and agency if child is in agency custody)

Date

For more information, visit ldh.la.gov/cshs