New _____ Recert _____
Date of Initial CSS _____

CHILDREN'S SPECIAL SERVICES APPLICATION
TENNESSEE DEPARTMENT OF HEALTH

County _____ Region _____
Local Chart # _____
Level of Care _____ I _____ II

Name _____ Date of Birth _____ Race _____ Sex ___ M ___ F
Last First Middle

Address _____ Phone Number _____ Social Security Number _____

City _____ Zip Code _____ Emergency Phone _____ Emergency Contact Name _____

Additional Address _____ Additional Address _____

_____ _____

_____ Social Security Number _____
Father or Guardian

_____ Social Security Number _____
Mother or Guardian

I wish to make application to Children's Special Services for my child, my ward or myself. I further authorize said program to obtain and release, by fax or mail, any medical records or other pertinent information, which will benefit or be in the best interest of my child, my ward or myself. I grant permission to obtain financial records needed in order to determine financial eligibility for assistance. I agree to assign all insurance benefits to the persons and/or health facility providing care to my child, ward or myself. This release is effective for a period of one year from the date signed.

Signed _____ Date _____
Parent or Guardian (relationship, grandparent, DCS, client etc.)

Application completed by _____ Date _____
Title

HEALTH INSURANCE:	Private	TennCare	CHAMPUS/ Other
Name			
Policy #			
Co-pay			
Effective Date			
Deductible			
Primary Care Provider			
PCP Phone #:			

Number in Family* _____

Gross Monthly Income _____

Monthly Health Insurance Amounts _____

Monthly Paid Medical Expenses (verification attached) _____

Monthly Child Support Paid to Another Household (verification attached) _____

Adjusted Gross _____

*If more than 1 child with a CSS eligible condition, add 1 to number in family: NAME(S) of other child (children) on CSS _____

COMMENTS: _____

Father/Guardian-Employer _____ Gross Monthly Income _____ Date of Employment _____ Phone Number _____
(Source of income) Verify

Mother/Guardian-Employer _____ Gross Monthly Income _____ Date of Employment _____ Phone Number _____
(Source of income) Verify

Other income _____ Temp.Assist (TANF) _____ SSI _____ SSA _____ Child Support _____ Spend down (Y or N) (end date) _____
(monthly) (Families First)

Cash on hand (checking, etc.) _____ Savings (CD's, etc.) _____ TennCare verified by: copy _____ computer _____

DIAGNOSES (and ICD 9 Code): _____

Eligibility Determination: Medical: ____ Care Coordination only _____ Pending _____ Eligible from _____ to _____

Regional Chart # _____ Determination made by: _____ Date: _____
CSS Regional Coordinator/Designee

PH-1700
Rev. 8-2000

RDA 409