



**CHILDREN'S SPECIAL SERVICES APPLICATION
TENNESSEE DEPARTMENT OF HEALTH**

New _____ Recert _____
Date of Initial CSS _____

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 _____

Father or Guardian _____ Social Security Number _____

Mother or Guardian _____ Social Security Number _____

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	Number in Family* _____
Name				Gross Monthly Income _____
Policy #				Monthly Health Insurance Amounts _____
Co-pay				Monthly Paid Medical Expenses (verification attached) _____
Effective Date				Monthly Child Support Paid to Another Household (verification attached) _____
Deductible				Adjusted Gross _____
Primary Care Provider				
PCP Phone #:				

*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