



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SPECIAL HEALTH CARE NEEDS (SHCN)
APPLICATION FOR ENROLLMENT

READ INSTRUCTIONS ON REVERSE FIRST.
PLEASE PRINT LEGIBLY IN BLACK INK.

SECTION A – PARTICIPANT INFORMATION (Individual being enrolled for services)		DCN	
1. NAME (LAST, FIRST, MIDDLE)		2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
4. ADDRESS (STREET, CITY, STATE, ZIP)		5. COUNTY	6. HOME TELEPHONE
		7. SEX	8. RACE
		9. PARTICIPANT/FAMILY DAYTIME PHONE	
10. RESPONSIBLE PARTY NAME		11. RESPONSIBLE PARTY E-MAIL ADDRESS	
12. PRIMARY CARE PHYSICIAN NAME AND ADDRESS		13. SPECIALIST PHYSICIAN NAME AND ADDRESS	
14. PROGRAM ENROLLMENT (CHECK ONE) <input type="checkbox"/> Adult Head Injury <input type="checkbox"/> Children and Youth with Special Health Care Needs <input type="checkbox"/> Healthy Children and Youth			
SECTION B - FAMILY INFORMATION (List all persons besides participant living in household)			
15. NAME (LAST, FIRST, MIDDLE).	16. DATE OF BIRTH	17. RELATIONSHIP	18. SHCN
PARENTS:			
OTHERS:			
19. DOES THE PARTICIPANT HAVE A COURT APPOINTED GUARDIAN? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Complete 20. TYPE OF GUARDIANSHIP _____		20. GUARDIAN NAME, ADDRESS AND TELEPHONE NUMBER	
21. ALTERNATE CONTACT NAME		22. ALTERNATE CONTACT TELEPHONE NUMBER	
SECTION C - FINANCIAL RESOURCES (Not applicable to HCY Program)			
23. Did you file a Federal Income Tax Form? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, attach a copy of the Income Tax Form. Do Not Send W-2. If no copy available, you should obtain a copy by calling the IRS at (800) 829-1040. If no, why did you not file? <input type="checkbox"/> Not required to file <input type="checkbox"/> Requested extension of filing date (attach copy) <input type="checkbox"/> Other			
24. Has family income changed since filing Income Tax? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of change _____ Estimate this year's current income _____			
25. Current Insurance Status (Check all that apply, include begin date and end dates of coverage) <input type="checkbox"/> NONE			
<input type="checkbox"/> MO HEALTHNET #	Begin Date	End Date	
<input type="checkbox"/> MEDICARE#	Begin Date	End Date	
<input type="checkbox"/> VETERAN'S ADMINISTRATION	Begin Date	End Date	
<input type="checkbox"/> PRIVATE INSURANCE (NAME)	Begin Date	End Date	
<input type="checkbox"/> OTHER (PLEASE SPECIFY)	Begin Date	End Date	
SECTION D - MEDICAL CONDITION OR PROBLEM			
SECTION E - SERVICES REQUESTED/NEEDED			
SECTION F - AUTHORIZATION TO RELEASE INFORMATION			
Application is made for admission of the above named participant to Special Health Care Needs. I authorize SHCN to release or obtain information to or from any agencies which are participating in the treatment and care plan for the applicant. The information on this application form may be exchanged with agencies that administer relevant or applicable programs. I consent to the release of personal, financial, and medical information from this application form and supporting documents to the agencies that administer relevant or applicable programs for establishing and verifying eligibility and for performing evaluations. I understand that the agencies that administer such programs will maintain confidentiality of this information according to the applicable laws. I have been informed that SHCN provides care on a nondiscriminatory basis as required by Title VI of the Civil Rights Act of 1964. I understand SHCN eligibility will not be considered until all information has been received by SHCN. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing or withholding facts may result in repaying in cash the value of benefits received. I understand any medical insurance benefits I may receive for services authorized by SHCN may be forwarded to the provider of service(s). I must cooperate with the providers of services and SHCN in giving all information concerning trust funds, legal actions, settlements and third party payors i.e., medical insurance, MO HealthNet, etc. I have been advised and understand my rights and responsibilities under SHCN. All the information I have provided is correct to the best of my knowledge.			
26. SIGNATURE OF PARENT/GUARDIAN		27. SIGNATURE OF PARTICIPANT 18 OR OLDER	
		28. DATE	

APPLICATION FOR ENROLLMENT

READ INSTRUCTIONS BEFORE COMPLETING FORM

SECTION A - PARTICIPANT INFORMATION

1. Enter participant's name (last, first, middle).
2. Enter participant's date of birth.
3. Enter participant's Social Security number.
4. Enter address (street, city, state, zip) where participant lives.
5. Enter county where participant lives.
6. Enter telephone number where participant lives.
7. Enter participant's sex.
8. Enter participant's race (W - White, B - Black, A - Asian, NA - Native American, PI - Pacific Islander, O - Other).
9. Enter participant/family daytime/work telephone number.
10. Enter the responsible party name.
11. Enter responsible party's email address.
12. Enter primary care physician name and address where participant receives his/her basic care (immunizations, etc.).
13. Enter physician name and address where participant receives his/her specialized care.
14. Program enrollment - check the box which best identifies the program in which the participant is interested.

SECTION B - FAMILY INFORMATION - List all persons besides participant living in household

15. Enter name of other individuals living in same household as participant.
16. Enter date of birth of other individuals living in the same household as participant.
17. Enter relationship of other individuals living in the same household with the participant.
18. If this individual receives services from Special Health Care Needs (SHCN) place a checkmark in the "SHCN" column.
19. If the participant has a court appointed guardian, check "Yes" and enter type of guardianship.
20. Enter guardian name, address, and telephone number.
21. Enter name of an alternate contact - someone not in this household who will know how to get in touch with the participant/family.
22. Enter telephone number of alternate contact person.

SECTION C - FINANCIAL RESOURCES (Not applicable to HCY and PDW Programs)

23. Check "Yes" if participant/family filed a Federal Income Tax Form. Attach a copy of the Federal Income Tax Form. DO NOT SEND A W-2 FORM. If participant/family does not have a copy of the Federal Income Tax Form, call (800) 829-1040 to obtain a copy from the IRS. Mail the copy to the service coordinator when it is received.
Check "No" if participant/family did not file a Federal Income Tax Form and indicate the reason for not filing. (Attach copy of extension.)
24. Check "Yes" if the family income has changed since filing Federal Income Tax. If income has changed, give date of change and enter this year's estimated income.
25. Current Insurance Status - Check the box(es) which describe participant's current insurance status. Include the begin and end date of coverage.

SECTION D - MEDICAL CONDITION OR PROBLEM

Describe medical condition or problem the participant is having.

SECTION E - SERVICES REQUESTED/NEEDED

Enter services desired.

SECTION F - AUTHORIZATION TO RELEASE INFORMATION AND APPLICANT SIGNATURE - MUST SIGN AND DATE HERE BEFORE THE APPLICATION WILL BE PROCESSED.

26. Signature of Parent/Guardian. If guardianship has been granted, guardian must sign.
27. Participant 18 or older must sign the application. Parent must sign along with participant 18 years or older when participant is listed on parent's Federal Income Tax form as a dependent.
28. Enter date of signature.