

# *Application For Assistance*



*Serving Children with  
Special Health Care Needs*

# You and Your Child With Special Health Care Needs

DSCC families tell us, *“Part of the problem of having a child with special needs is finding out what they need, where to get it, and how to pay for it.”* For many families, finding the resources for their child can be difficult. And then your child’s needs change as he or she grows.

If your child is eligible, a DSCC care coordination team is prepared to work with you to find the help your child needs. As one parent said, *“The (care coordinators) have always been helpful and a calming voice in a sometimes crazy world of illness.”*



**For more information about DSCC, please see our brochure  
or visit our website:**

**[www.uic.edu/hsc/dsccl](http://www.uic.edu/hsc/dsccl)**

## DSCC MAY BE ABLE TO HELP YOU AND YOUR CHILD

- Link to specialty care and other health services
- Work with your child’s doctors to make sure the health care team stays informed
- Build a service plan to help with your child’s needs
- Link to other services and groups in your community that might help as your child grows
- Learn about rights, including your child’s early intervention or education rights
- Partner with the school to address your child’s special health needs
- Learn how to use your private health insurance or public health insurance program (All Kids/Medicaid)
- Learn about your child’s condition
- Link to other parents
- Advocate if things get in the way of getting care for your child
- Find answers to your questions
- Help pay for certain specialty medical care not covered by other payers if you meet financial eligibility guidelines
- Help pay transportation to your child’s specialty care appointments if you meet financial eligibility guidelines
- Coordinate your child’s care

**DSCC will keep all information on this application private,  
unless you provide written permission.**

**For help completing this application, contact the Regional Office serving your area.  
If you do not know which office is serving your area, you may contact DSCC at:**

**1-800-322-3722 (Voice)      1-217-785-4728 (TTY)**

**We look forward to receiving your child’s completed application.**



The Application for Assistance has five (5) Sections: General Information, Health Information, Paying for Your Child's Health Care, Applying Parent Certification and Financial Application. Please print clearly.

GENERAL INFORMATION

1. Tell Us About Your Child

Legal Name (Last) (First) (Middle) Birthdate (Month/Day/Year)

Has your child received medical treatment under any other name? If yes, (Last) (First) (Middle)

Phone ( ) (Home) ( ) (Work) ( ) (Cell) ( ) (Other)

Street Address

City State Zip County

Child Residency/Citizenship:

Lives in Illinois? Yes No Is a citizen of US? Yes No -> If no, is your child permanently admitted to US? Yes No

Race: (optional)

African American Hispanic American Indian White Asian Other

Gender: Male Female

2. Tell Us About the Applying Parent or Legal Guardian (usually the person filling out the form)

Legal Name (Last) (First) (Middle)

Relationship to Child: Father Mother Other

Birthdate (Month/Day/Year) Social Security #

Phone ( ) (Home) ( ) (Work) ( ) (Cell) ( ) (Other)

Best Time to Phone (DSCC's hours are 8:00 AM to 4:30 PM, Monday through Friday)

Address: Check if same as child or complete below

Street Address

City State Zip County

Parent Residency/Citizenship:

Lives in Illinois? Yes No Is a citizen of US? Yes No -> If no, are you permanently admitted to US? Yes No

Do You Have Legal Guardianship? Yes No, explain

What Language Do You Use the Most? English Spanish Other

(Continue on Page 2)

DSCC ID: FOR DSCC USE ONLY

**3. Tell Us About Any Other Parent or Legal Guardian (if applicable)**

Legal Name \_\_\_\_\_  
(Last) (First) (Middle)

Relationship to Child: Father Mother Other \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security #  -  -   
(Month/Day/Year)

Phone (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
(Home) (Work) (Cell) (Other)

Best Time to Phone \_\_\_\_\_ *(DSCC's hours are 8:00 AM to 4:30 PM, Monday through Friday)*

Address: Check if same as child or complete below

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

**Parent Residency/Citizenship:**

Lives in Illinois? Yes No  
 Is a citizen of US? Yes No → If no, are you permanently admitted to US? Yes No

**Do You Have Legal Guardianship?** Yes No, explain \_\_\_\_\_

**What Language Do You Use the Most?** English Spanish Other \_\_\_\_\_

**HEALTH INFORMATION**

**4. Tell Us About Your Child's Health Issues**

What is/are your child's health issue(s)? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How long have you known about this/these health issue(s)? \_\_\_\_\_

Who is the doctor that is treating your child's health issue(s)? \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

What kinds of treatments has your child needed for this/these health issue(s) up to now? *(check all that apply)*

Visits to doctor Hospital stays Surgery Other \_\_\_\_\_

In the past six (6) months, what doctors and hospitals have treated your child? *(attach additional page if needed)*

Doctor or Hospital	City/State
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



**If your child received medical care in the last thirty (30) days, please call us right away to see if we can help pay certain medical bills for this care.**

**(Continue on Page 3)**

**DSCC ID:** \_\_\_\_\_  
**FOR DSCC USE ONLY**

## PAYING FOR YOUR CHILD'S HEALTH CARE

We need to know how you pay for your child's health care. This information allows us to help you plan your child's care, and make sure you are able to use your private health insurance or public health insurance program (All Kids/Medicaid).

### 5. Tell Us About the Employment Information *(for the person who usually pays your child's medical bills)*

Name of Employee \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Employer Phone Number \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### 6. Tell Us About Your Child's Health Insurance *(private or public)*

Check all that apply:

My child **is not** covered by a private health insurance policy or a public health insurance program (All Kids/Medicaid).  
(Go to Number 7)

My child **is** covered by a private health insurance policy/policies. (Please complete below and send a copy of the front and back of your insurance card.)

Name of Policyholder (Insured) \_\_\_\_\_

Insurance Identification or Member Number \_\_\_\_\_

Name of Insurance Company/Plan \_\_\_\_\_

My child **is** covered by a public health insurance program (All Kids/Medicaid). (Please complete below and send a copy of your eligibility letter or card from All Kids/Medicaid.)

Case Number

Recipient Number

## APPLYING PARENT CERTIFICATION

### 7. Tell Us if You Are Involved in Legal Action Regarding Your Child's Medical Care

Are you involved in medical legal action regarding your child?    Yes        No   

### 8. Tell Us if You Are Currently Receiving Supplemental Security Income (SSI) for Your Child

Does your child receive SSI?    Yes        No   

### 9. Please Read and Sign

I certify that the information given on this application is correct to the best of my knowledge. I further certify that I am legally entitled to make decisions about and provide for the special medical care needed by the child for which I am submitting this application.

I have received the Notice of Privacy Practices

I have been offered the Notice of Privacy Practices but decline because \_\_\_\_\_

\_\_\_\_\_  
Signature of Applying Parent/Guardian

\_\_\_\_\_  
Date

**(If you are interested in finding out if we can pay certain medical bills for your child, continue on Page 4)**

**DSCC ID:** \_\_\_\_\_  
**FOR DSCC USE ONLY**



# What Happens After I Send My Child's Application?

## IF YOUR CHILD HAS AN ELIGIBLE MEDICAL CONDITION

Your child can receive our care coordination services at no cost to you. A member of your care coordination team will talk to you about how we can help. We may be able to help you:

- Link to specialty care and other health services
- Work with your child's doctors to make sure the health care team stays informed
- Build a service plan to help with your child's needs
- Link to other services and groups in your community that might help as your child grows
- Learn about rights, including your child's early intervention or education rights
- Partner with the school to address your child's special health needs
- Learn how to use your private health insurance or public health insurance program (All Kids/Medicaid)
- Learn about your child's condition
- Link to other parents
- Advocate if things get in the way of getting care for your child
- Find answers to your questions
- Coordinate your child's care

## IF YOUR CHILD IS ELIGIBLE FOR DSCC HELP WITH CERTAIN MEDICAL BILLS

We will let you know if your child is eligible for help with certain medical bills based upon the proof of income you sent in with this application. We may also be able to help with transportation to your child's specialty care appointments. A member of your care coordination team will contact you and send information on how to use DSCC financial help. It is important to remember that you must always:

- Talk to us before scheduling any care to see if we can help with payment
- Use your private health insurance or public health insurance program (All Kids/Medicaid)
- Remember, if your child has had a service in the past month and you want to see if DSCC can help pay for that service, we **must** receive your completed application within thirty (30) days of the date the service was received

## IF YOUR CHILD IS NOT ELIGIBLE FOR DSCC

It is our goal to see if we can find help for your child. We will give you information on other programs, groups and resources. Please call us any time with questions regarding possible programs and resources for your child.



**Before you send us your child's application, use the checklist on the back to see if you are sending us everything we need.**

# Application Checklist

Check off items below to make sure you are sending us everything we need.

Signed and dated Applying Parent Certification (Page 3)

Attached a copy, front and back, of your insurance card(s) or All Kids/Medicaid Eligibility Letter *(if applicable)*

Enclosed copies of proof of income, if you are applying for DSCC financial assistance **(select one)**:

Copy of most current Federal Income Tax Return (Form 1040, 1040A, 1040EZ)

**OR**

Copy of most current Federal Income Tax Return (Form 1040, 1040A, 1040EZ) and a copy of wage statements (two [2] consecutive wage statements for pay periods within two [2] months from the date of this application for each wage earner in the family) if the tax return does not reflect current income or family size

**OR**

Copy of wage statements if you are not required to file Federal Income Taxes

**OR**

Copy of Illinois Hemophilia Program Eligibility Letter, if your child is receiving benefits from the Illinois Hemophilia Program

Copied this application packet for your records

Recorded the date this application was mailed \_\_\_\_\_

Recorded the date to follow-up with your care coordination team member \_\_\_\_\_ (thirty [30] days from the date this application was mailed)

Detached this page for your records



**Remember, once we get this application and signed *Authorization to Release Health Information* forms, we will request your child's medical reports. After the medical reports are received, we will contact you to let you know if your child is eligible for DSCC.**

**If you have any questions about this application, contact the Regional Office serving your area.  
If you do not know which office is serving your area, you may contact DSCC at:**

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