

UIC

UNIVERSITY
OF ILLINOIS
AT CHICAGO

**DIVISION OF SPECIALIZED
CARE FOR CHILDREN**



***Application For
Assistance***

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/dsc/

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 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.



APPLICATION FOR ASSISTANCE

DIVISION OF SPECIALIZED CARE
FOR CHILDREN

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

GENERAL INFORMATION

1. Tell Us About Your Child

Legal Name _____
(Last) (First) (Middle)

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

Street Address _____

City _____ State _____ Zip _____ County _____

Birthdate _____ Social Security # [][][] - [][] - [][][][]
(Month/Day/Year)

Child Residency/Citizenship:

Lives in Illinois? Yes No
Is a citizen of US? Yes No
If not a citizen, is your child permanently admitted to US? Yes No

Sex: Male Female

Race: (you can help by answering, but do not have to tell us)
 African American Hispanic
 American Indian White
 Asian Other _____

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 _____ Social Security # [][][] - [][] - [][][][]
(Month/Day/Year)

Phone (____) _____ (____) _____ (____) _____ (____) _____
(Home) (Work) (Cell) (Other)

Best Time to Phone: AM PM (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 _____

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)

(continue on page 2)

DSCC ID: _____
FOR DSCC USE ONLY

3. Tell Us About Any Other Parent or Legal Guardian (continued)

Phone (____) _____ (Home) (____) _____ (Work) (____) _____ (Cell) (____) _____ (Other)

Best Time to Phone: AM PM (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 health issue 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.

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 _____

(continue on page 3)

DSCC ID: _____
FOR DSCC USE ONLY

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)
- My child **is** covered by a private health insurance policy/policies
- My child **is** covered by a public health insurance program (All Kids/Medicaid)

Complete if your child has private health insurance. Please send us 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 _____

Complete if your child is covered by a public health insurance program (All Kids/Medicaid). Please send a copy of your eligibility letter or card from All Kids/Medicaid.

Case Number

Recipient Number

FINANCIAL INFORMATION

If you do not wish to apply for DSCC financial help, you **do not** need to complete this section. (**Go to Number 12**)

If you are interested in finding out if we can pay certain medical bills for your child, DSCC must know about your family's income and all available sources of payment. All financial information is confidential and will not be released without your permission. (**Go to Number 7**)



If you are not sure about what proof of income to send, 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)

7. Tell Us About the Proof of Income You Are Sending (send copies, not original documents)

Check a box below to tell us what kind of proof of income you are sending with this application:

- I am attaching a copy of my most current Federal Income Tax Return (Form 1040, 1040A, 1040EZ).** (**Go to Number 10**)
- I am attaching a copy of my most current Federal Income Tax Return (Form 1040, 1040A, 1040EZ) and a copy of wage statements.** The enclosed Federal Income Tax Return does not accurately reflect my: Current Income Family Size
Tell us why: _____ (**Go to Number 8**)
- I am not required to file a Federal Income Tax Return.** I am sending a copy of wage statements.
Tell us why: _____ (**Go to Number 8**)
- I am receiving benefits for my child from the Illinois Hemophilia Program.** I am attaching a copy of my Illinois Hemophilia Program eligibility letter. (**Go to Number 10**)
- I am not required to file a Federal Income Tax Return and do not receive wage statements.** I am submitting other proof of income.
Tell us why: _____ (**Go to Number 9**)

8. Tell Us About Your Family Wages

Attach a copy of your wage statements if you are not required to file a Federal Income Tax Return or if the attached Federal Income Tax Return does not accurately reflect your current income or family size.

Attach wage statements from two (2) **consecutive** pay periods for each wage earner in the family. The pay period dates cannot be older than two (2) months from the date of this application.

(continue on page 4)

DSCC ID: _____
FOR DSCC USE ONLY

9. Tell Us About Your Additional Family Income

Complete if the enclosed Federal Income Tax Return does not accurately reflect your current income or family size, if you are not required to file a Federal Income Tax Return or if you do not receive wage statements.

Enter the amounts of additional income expected for the next twelve (12) months. *(round to nearest dollar)*

Examples: Profits from Corporations and Partnerships; Capital Gains; Salary bonuses; Alimony received; Interest and Dividend income; Unemployment compensation; Rental income; Social Security benefits other than Supplemental Security Income (SSI) benefits, etc.

| Source | Annual Amount |
|--------|---------------|
| _____ | \$ _____ |
| _____ | \$ _____ |

Please list all dependents (e.g., children, stepchildren and grandparent[s]) living in your home:

| Name <i>(first, middle initial and last)</i> | Relationship <i>(e.g., son, daughter, stepchild, grandparent)</i> | Birthdate |
|---|--|-----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Total Family Size _____

10. Financial Information Certification *(please certify that the financial information you are providing is correct)*

I certify that the income information I have provided is correct to the best of my knowledge. Providing false information can result in immediate loss of any financial assistance provided by DSCC and legal action to recover any amounts previously paid by DSCC.

Signature of Financially Responsible Parent/Guardian

Date

11. 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

APPLYING PARENT CERTIFICATION

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

Does your child receive SSI? Yes No

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

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 this *Application for Assistance*
- Attached a copy, front and back, of the insurance(s) or All Kids/Medicaid eligibility letter or card (*if applicable*)
- Completed and signed the **Financial Information** Section and enclosed copies of the required proof of income, if you are applying for DSCC 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 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)
 - OR**
 - 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)
 - OR**
 - Copy of Illinois Hemophilia Program eligibility letter, if your child is receiving benefits from the Illinois Hemophilia Program
 - OR**
 - Copy of other proof of income
- Copied this application packet for your records (*if you want*)
- 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 (*if you want*)



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:

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