

Application
Illinois Provider Directory For Children With Special Health Care Needs & Their Families

PROVIDER INFORMATION
(Note: Bold fields are required information.)

First Name: _____ **Last Name:** _____

E-mail Address: _____

(Your email address will be your login name and will be used to correspond with you about your listing.)

Phone Number where you can be reached (include area code): _____

Gender (optional): Male Female

Check all that apply:

- Board Certified M.D.
- DSCC Approved Provider
- Medicaid Provider
- Managed Care Association Member (List the plans you participate in)

If certification is in process for any of the above, please explain: _____

Specialty(ies) (Check all that apply):

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Allergist/Immunologist | <input type="checkbox"/> Family Physician | <input type="checkbox"/> Ocularist | <input type="checkbox"/> Prosthodontist |
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Gastroenterologist | <input type="checkbox"/> Ophthalmologist | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Cardiac Surgeon | <input type="checkbox"/> Hearing Aid Dispenser | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Hematologist/Oncologist | <input type="checkbox"/> Oral Surgeon | <input type="checkbox"/> Psychologist (Developmental) |
| <input type="checkbox"/> Counselor | <input type="checkbox"/> Internist | <input type="checkbox"/> Orthodontist | <input type="checkbox"/> Psychologist (School) |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Marriage and Family Therapist | <input type="checkbox"/> Orthopedic Surgeon | <input type="checkbox"/> Pulmonologist |
| <input type="checkbox"/> Dermatologist | <input type="checkbox"/> Medical Geneticist | <input type="checkbox"/> Orthotist | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Developmental Pediatrician | <input type="checkbox"/> Neonatologist | <input type="checkbox"/> Pediatric Infectious Disease | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Developmental Therapist | <input type="checkbox"/> Nephrologist | <input type="checkbox"/> Pediatric Rehab. Medicine | <input type="checkbox"/> Speech Therapist |
| <input type="checkbox"/> Dietitian | <input type="checkbox"/> Neurodevelopmental Disabilities | <input type="checkbox"/> Pediatric Surgeon | <input type="checkbox"/> Surgeon – General |
| <input type="checkbox"/> DME Provider | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Pediatrician – General | <input type="checkbox"/> Thoracic Surgeon |
| <input type="checkbox"/> Dymorphologist | <input type="checkbox"/> Neurophthalmologist | <input type="checkbox"/> Physiatrist | <input type="checkbox"/> Urologist |
| <input type="checkbox"/> Endocrinologist | <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Physical Therapist | |
| <input type="checkbox"/> Endodontist | <input type="checkbox"/> Nutritionist | <input type="checkbox"/> Podiatrist | |
| <input type="checkbox"/> ENT (Otolaryngologist) | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Prosthetist | |

List any of your specialties not listed above: _____

Personal comments (Enter any information you would like to share about yourself here, including any other certifications, licenses or other information for public display):

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OFFICE/PRACTICE INFORMATION

Note: Bold fields are required information.

Office/Practice Name: _____

Phone Number: _____ **Extension:** _____

Office Fax Number: _____

Office E-mail Address: _____

Office Web Address: _____

Office Address: _____

City: _____ **State:** _____ **Zip Code:** _____

County (leave blank if not in Illinois): _____

Practice Services (Check all that apply):

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Developmental Testing | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Phenylketoneuria (PKU) Treatment |
| <input type="checkbox"/> Allergy Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus | <input type="checkbox"/> Physical Medicine Rehabilitation |
| <input type="checkbox"/> Allergy Testing | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Maxillofacial Surgery | <input type="checkbox"/> Physical Therapy (PT) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ear, Nose & Throat Problems | <input type="checkbox"/> Medical Home Provider | <input type="checkbox"/> Plastic Surgery Services (Pediatric) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Mental Health Services (Early Childhood – ages Birth to 5) | <input type="checkbox"/> Prosthetics |
| <input type="checkbox"/> Attention Deficit / Hyperactivity | <input type="checkbox"/> Endocrinology Services (Pediatric) | <input type="checkbox"/> Mental Health Services (Infant – ages Birth to 3) | <input type="checkbox"/> Pulmonology Services |
| <input type="checkbox"/> Audiology | <input type="checkbox"/> ENT Services | <input type="checkbox"/> Metabolic Problems | <input type="checkbox"/> Reconstructive Surgery |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Rheumatology Services (Pediatric) |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Neurodevelopmental Disabilities | <input type="checkbox"/> School Behavior Problems |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Failure to Thrive | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> School Learning Problems |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Family Physician Services (Routine) | <input type="checkbox"/> Neurology Services (Pediatric) | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Feeding Problems | <input type="checkbox"/> Neurosurgery Services (Pediatric) | <input type="checkbox"/> Seizure Problems |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Gastroenterology Services | <input type="checkbox"/> Obesity | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Blood Problems | <input type="checkbox"/> Genetic Counseling | <input type="checkbox"/> Occupational Therapy (OT) | <input type="checkbox"/> Sinus Disorders |
| <input type="checkbox"/> Bone/Joint Problems | <input type="checkbox"/> Genetic Disorders | <input type="checkbox"/> Oculoplastic Surgery | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> Botulinum Toxin (BOTOX) Treatment | <input type="checkbox"/> Hand Surgery | <input type="checkbox"/> Oncology Services (Pediatric) | <input type="checkbox"/> Social/Emotional Support Services |
| <input type="checkbox"/> Bowel Disease | <input type="checkbox"/> Head & Neck Surgery | <input type="checkbox"/> Ophthalmology Services (Pediatric) | <input type="checkbox"/> Spasticity Management |
| <input type="checkbox"/> Braces (Orthotics) | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Orthodontic Services (Pediatric) | <input type="checkbox"/> Speech/Communication Problems |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Heart Catheterization | <input type="checkbox"/> Orthopedic Services (Pediatric) | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Burn Care | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Orthotics (Braces) | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Ostomy Care | <input type="checkbox"/> Spine Surgery |
| <input type="checkbox"/> Cardiology Services | <input type="checkbox"/> Hematology Services (Pediatric) | <input type="checkbox"/> Pacemakers | <input type="checkbox"/> Sports Medicine Services |
| <input type="checkbox"/> Case Management / Advocacy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pain Management | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pediatric Services (Routine) | <input type="checkbox"/> Surgical Services (Pediatric) |
| <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Periodontics | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Counseling Services (Adolescent) | <input type="checkbox"/> HIV/AIDS Treatment | <input type="checkbox"/> Pervasive Developmental Delay | <input type="checkbox"/> Wheelchair Evaluations |
| <input type="checkbox"/> Counseling Services (Pediatric) | <input type="checkbox"/> Home Visiting | | |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Immune Disorders | | |
| <input type="checkbox"/> Dental Care | <input type="checkbox"/> Joint Surgery | | |
| <input type="checkbox"/> Developmental Screening | <input type="checkbox"/> Kidney Problems | | |
| <input type="checkbox"/> Developmental Services | <input type="checkbox"/> Knee & Hip Surgery | | |
| | <input type="checkbox"/> Laser Surgery | | |
| | <input type="checkbox"/> Liver Problems | | |

List any of your practice's specialties not listed above: _____