

CSHCS MEDICAL ELIGIBILITY REPORT

Instructions for Form MSA-4114

Purpose:

This form is used to determine if an individual is medically eligible for the Children's Special Health Care Services (CSHCS) program. The condition must require the services of a medical and/or surgical sub-specialist at least annually, as opposed to being managed exclusively by a primary care physician. A current list of covered diagnoses is maintained on the MDHHS website at www.michigan.gov/mdhhs. In addition, some diagnoses must meet severity or chronicity criteria (e.g. asthma).

This form should be completed for the following persons:

- Anyone **UNDER 26** years of age with a potentially eligible condition. Psychiatric, emotional and behavioral disorders, attention deficit disorder, developmental delay, intellectual disability, autism, or other mental health diagnoses are **not** conditions covered by the CSHCS program.
- Anyone, regardless of age, with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia.

Completion Instructions:

- Read this instruction page thoroughly. Then separate attached forms.
- **TYPE** or **PRINT** clearly in INK.
- The **Physician's Signature** (or the Attending Physician if a Hospital) and the **Date Signed** are **REQUIRED**.
- Attach supporting medical documentation.
- If desired, make a photocopy for your records.
- **FAX** the completed form to **the CSHCS Division at 517-335-9491**.

Other Information:

- If this request is approved, the client is medically eligible for the CSHCS program.
- For actual program coverage, the client or the client's family **MUST APPLY** to join the CSHCS program by completing form **MSA-0737, APPLICATION FOR CHILDREN'S SPECIAL HEALTH CARE SERVICES**.
- If the family does **NOT** receive an application after notification of approval, call **1-800-359-3722**.

MEDICAL ELIGIBILITY REPORT

CLIENT INFORMATION:

CLIENT'S Name (Last, First, Middle)			Date of Birth	Sex <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
CLIENT'S Address (Number, Apt. No., Lot No.)			Social Security Number	HOME Phone Number () -
City	State	ZIP Code	County	WORK Phone Number () -
Does client have other health insurance? <input type="checkbox"/> NO <input type="checkbox"/> YES (Co. Name):			Is client enrolled in Medicaid? <input type="checkbox"/> NO <input type="checkbox"/> YES (Medicaid ID No.):	
Racial/ Ethnic Heritage (Check all that apply) (You are not required to complete this information.) <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> Arabic <input type="checkbox"/> Asian <input type="checkbox"/> African American/Black <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Multi-racial/Ethnic <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other:				

PARENT(S) OR LEGALLY RESPONSIBLE PARTY INFORMATION: (Check appropriate boxes and complete information.)

<input type="checkbox"/> FATHER or <input type="checkbox"/> LEGALLY RESPONSIBLE PARTY Name			<input type="checkbox"/> MOTHER or <input type="checkbox"/> LEGALLY RESPONSIBLE PARTY Name		
Street Address (if different from client's)			Street Address (if different from client's)		
City	State	ZIP Code	City	State	ZIP Code
Social Security Number	Relationship to Client		Social Security Number	Relationship to Client	
HOME Phone Number () -	WORK Phone Number () -		HOME Phone Number () -	WORK Phone Number () -	
Email Address			Email Address		

CLIENT MEDICAL NEEDS INFORMATION:

DIAGNOSIS (If Newborn, give birth weight) Primary:		Other:	
SEVERITY/COMPLICATIONS/CHRONICITY			
HISTORY			
TREATMENT PLAN (Include names of specialists involved, and any special needs such as surgery, medications, supplies, therapies, equipment)			
What care will this client need? <input type="checkbox"/> HOSPITAL <input type="checkbox"/> HOME CARE <input type="checkbox"/> Other (explain) -			Requested Coverage Begin Date
PROGNOSIS:			
HOSPITAL Name		Hospital Case Record Number	
Hospital Contact Person (Name and Title)		Hospital Phone Number () -	
PHYSICIAN'S Name (Print)		Physician's Phone Number () -	
Physician's Address (Number and Street)		Physician's Signature (REQUIRED)	Date Signed
City	State		

For CSHCS Use Only

<input type="checkbox"/> APPROVED - The client must now complete enrollment process for coverage. This client is medically eligible for the CSHCS Program for diagnosis code(s): _____	CSHCS Signature _____ Date _____
<input type="checkbox"/> DISAPPROVED - This client is NOT medically eligible for the CSHCS Program. Reason: _____	
<input type="checkbox"/> Eligible for diagnostic evaluation at: _____ _____	
<input type="checkbox"/> Pending / Other:	

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

AUTHORITY: Title V of the Social Security Act

COMPLETION: Completion is voluntary but is required if coverage under the Children’s Special Health Care Services program is desired.

Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages.

If you need these services, contact the Section 1557 Coordinator. The contact information is found below.

If you believe that MDHHS has not provided the above services, or discriminated in another way, you can file a grievance with the Section 1557 Coordinator. You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
Compliance Office, Suite 411
PO Box 30037
Lansing, MI 48909

517-284-1018 (Main), (TTY number—if covered entity has one), 517-335-6146 (Fax),
MDHHS-Section-1557@michigan.gov (Email).

You can also file a civil rights complaint with the responsible federal agency.

<p>If your grievance or complaint is about your Medicaid application, benefits or services, you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at:</p> <p>U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD)</p> <p>Complaint forms are available at https://bit.ly/2IKsHMS.</p>	<p>If your grievance or complaint is about your application for current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by:</p> <p>Completing a Complaint Form-(AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all the information requested in the form.</p> <p>To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410</p> <p>Fax: 202-690-7442; or Email: program.intake@usda.gov</p>
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MDHHS is an equal opportunity provider.