TEXAS
Health and Human Services

Children with Special Health Care Needs Services

Texas Health and Human Services Commission

Children with Special Health Care Needs (CSHCN) Services Program Application

Instructions:

1. Complete all sections.
2. Print in dark ink.
3. Sign and date page 9.
4. Have a doctor or dentist fill out the Physician/Dentist Assessment Form (Form T-4).
5. Attach all necessary documents.
6. Return to your regional CSHCN office (a list of offices begins on page 12).

Call your regional office or 1-800-252-8023 if you have any questions.

Language services are available to you at no cost.

Applicant Information

Tell us about the person who needs our help.
Use the name as it appears on the proof of birth document.

First name:	Middle name:	Last name:
☐ Female ☐ Male	CSHCN Client ID #:	
Date of birth:	Social Security number:	
Date of Texas residency:	If born in Texas, use date of birth. Otherwise, use the first day of the month moved to Texas.	
☐ U.S. citizen ☐ Non-citizen ☐ Eligible Immigrant		

Proof of birth date. First-time applicants, send us one of the following: Birth certificate, passport, Bureau of Vital Statistics record, adoption records, Medicaid ID, CHIP card, hospital or public health birth record, Native American census record, immigration documents, paternity records from the Attorney General, Social Security Administration records, court or child-support orders, or school or day care records (call your Regional Office for form).

Contact Information

Home address:		
City:	State:	ZIP code:
Mailing address (if different):		
City:	State:	ZIP code:
Home phone:	Work phone:	Cell phone:
Email address:		

Proof of Residency. Proof must show the parent or guardian name and the home address you listed above. Proof must also be unexpired and dated within the time frame listed below. Examples of common proofs include:

- utility bill from the last 60 days
- valid Texas Driver License or ID card
- valid Texas Voter Registration
- rent receipt or mortgage payment in the last 60 days
- current lease
- any current Medicaid ID
- school records for current school year (Call your local office for a form)

If you have questions about a proof of residency, call 1-800-252-8023.

Language Preferences		
Preferred spoken language:	☐ English	☐ Spanish
Which language would you like written correspondence in?	☐ English	☐ Spanish

Income Information

Self-employed. Please send the most recent tax return showing adjusted gross income, receipts for expenses from the last 60 days, and the Self-Employment Income form (call Regional office for form).

What sources of income do you have?

- ☐ No household income
- ☐ Employment
- ☐ Self-employment
- ☐ Unemployment benefits
- ☐ SSI (Do not include the applicant's SSI income.)
- ☐ Child support
- ☐ VA, retirement, or railroad pension
- ☐ Dividends or royalties
- ☐ Rental property
- ☐ Other:

What is the pay cycle for this source of income?

- ☐ Weekly
- ☐ Every two weeks
- ☐ Twice per month
- ☐ Monthly
- ☐ Yearly

Proofs of income. You must send proof of every source of income for every member of your household that is **legally obligated** to support the applicant.

Proofs must be dated from the last 60 days and be one of the following:

- Paycheck stubs;
- Signed letter from employers;
- Bank statement that shows direct deposit of benefits;
- SSI check or award letter;
- Medicaid Form 1028;
- Unemployment benefit award letter;
- Divorce decree, Attorney General document, or cancelled check showing the amount of child support; or
- CSHCN Services Program Employment Verification form (call Regional office for form).

If you have questions about income verification, call 1-800-252-8023.

Household Information

Provide information for each additional person who lives in your house.

First name:	Middle name:	Last name:

Date of birth:

☐ U.S. citizen ☐ Non-citizen ☐ Eligible Immigrant

Is this person legally responsible for the applicant? ☐ Yes ☐ No

Can this person speak for the applicant? ☐ Yes ☐ No

Relationship to applicant:

- ☐ Parent/Guardian
- ☐ Brother/sister
- ☐ Spouse
- ☐ Child
- ☐ Caregiver
- ☐ Other:

Home phone:	Work phone:	Cell phone:

Email address:

What sources of income does this person have?

- ☐ No household income
- ☐ Employment
- ☐ Self-employment
- ☐ Unemployment benefits
- ☐ SSI (Do not include the applicant's SSI income.)
- ☐ Child support
- ☐ VA, retirement, or railroad pension
- ☐ Dividends or royalties
- ☐ Rental property
- ☐ Other:

What is the pay cycle for this source of income?

- ☐ Weekly
- ☐ Every two weeks
- ☐ Twice per month
- ☐ Monthly
- ☐ Yearly

Additional Household Member		
First name:	Middle name:	Last name:
Date of birth:		
☐ U.S. citizen ☐ Non-citizen ☐ Eligible Immigrant		
Is this person legally responsible for the applicant? ☐ Yes ☐ No		
Can this person speak for the applicant? ☐ Yes ☐ No		
Relationship to applicant: ☐ Parent/Guardian ☐ Brother/sister ☐ Spouse ☐ Child ☐ Caregiver ☐ Other:		
Home phone:	Work phone:	Cell phone:
Email address:		

What sources of income does this person have?

- ☐ No household income
- ☐ Employment
- ☐ Self-employment
- ☐ Unemployment benefits
- ☐ SSI (Do not include the applicant's SSI income.)
- ☐ Child support
- ☐ VA, retirement, or railroad pension
- ☐ Dividends or royalties
- ☐ Rental property
- ☐ Other:

What is the pay cycle for this source of income?

- ☐ Weekly
- ☐ Every two weeks
- ☐ Twice per month
- ☐ Monthly
- ☐ Yearly

Additional Household Member		
First name:	Middle name:	Last name:
Date of birth:		
☐ U.S. citizen ☐ Non-citizen ☐ Eligible Immigrant		
Is this person legally responsible for the applicant? ☐ Yes ☐ No		
Can this person speak for the applicant? ☐ Yes ☐ No		
Relationship to applicant: ☐ Parent/Guardian ☐ Brother/sister ☐ Spouse ☐ Child ☐ Caregiver ☐ Other:		
Home phone:	Work phone:	Cell phone:
Email address:		

What sources of income does this person have?

- ☐ No household income
- ☐ Employment
- ☐ Self-employment
- ☐ Unemployment benefits
- ☐ SSI (Do not include the applicant's SSI income.)
- ☐ Child support
- ☐ VA, retirement, or railroad pension
- ☐ Dividends or royalties
- ☐ Rental property
- ☐ Other:

What is the pay cycle for this source of income?

- ☐ Weekly
- ☐ Every two weeks
- ☐ Twice per month
- ☐ Monthly
- ☐ Yearly

Additional Household Member		
First name:	Middle name:	Last name:
Date of birth:		
☐ U.S. citizen	☐ Non-citizen	☐ Eligible Immigrant
Is this person legally responsible for the applicant?	☐ Yes	☐ No
Can this person speak for the applicant?	☐ Yes	☐ No
Relationship to applicant:	☐ Parent/Guardian ☐ Brother/sister ☐ Spouse ☐ Child ☐ Caregiver ☐ Other:	
Home phone:	Work phone:	Cell phone:
Email address:		

What sources of income does this person have?

- ☐ No household income
- ☐ Employment
- ☐ Self-employment
- ☐ Unemployment benefits
- ☐ SSI (Do not include the applicant's SSI income.)
- ☐ Child support
- ☐ VA, retirement, or railroad pension
- ☐ Dividends or royalties
- ☐ Rental property
- ☐ Other:

What is the pay cycle for this source of income?

- ☐ Weekly
- ☐ Every two weeks
- ☐ Twice per month
- ☐ Monthly
- ☐ Yearly

If you have additional members of your household, attach additional copies of this page.

Insurance Information	
☐ The applicant is not covered under any medical or dental insurance.	
☐ The applicant has coverage, which is described below.	
Does the applicant have any kind of Medicaid? ☐ Yes ☐ No	
Medicaid number:	Medicaid includes SNAP (food stamps), TANF, Medicaid Buy-in for Children, and other programs.
Does the applicant have CHIP? ☐ Yes ☐ No	
CHIP number:	Coverage start date:
Medical provider name:	Dental provider name:
Does the applicant have Medicare Part A? ☐ Yes ☐ No	
Medicare (HICN) number:	Part A start date:
Does the applicant have Medicare Part B? ☐ Yes ☐ No	
Part B start date:	
Does the applicant have Medicare Part C? ☐ Yes ☐ No	
Part C start date:	
Does the applicant have Medicare Part D? ☐ Yes ☐ No	
Part D start date:	
Does the applicant have any kind of Medigap, or Medicare supplemental coverage? ☐ Yes ☐ No	
Member ID number:	Plan name:
Coverage start date:	Phone Number:

Make sure to read the **Coverage Attestation** on the signature page.

Private Insurance Information		
Does the applicant have any kind of private insurance?	☐ Yes	☐ No
Does the policy cover medical costs?	☐ Yes	☐ No
Does the policy cover prescriptions?	☐ Yes	☐ No
Insurance provider name:	Provider phone number:	
Member/policy number:	Coverage start date:	
Member/policy holder name:	Member Social Security number:	
Employer name:	Employer phone number:	
Monthly premium:		
Do you need help paying this premium?	☐ Yes	☐ No

Proof of insurance. You must send a copy of an ID card (front and back) or official letter for each and every type of coverage.

This application is **incomplete** without:

- ☐ Proof of birthdate (first-time applicants)
- ☐ Proof of residency
- ☐ Proofs of income for all household adults
- ☐ Proofs of all of the applicant's medical and dental coverage
- ☐ Your signature and date on the next page
- ☐ Physician/Dentist Assessment Form signed and dated by your doctor or dentist

Privacy Notification

With few exceptions, you have the right to request information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. (Government Code, Section 552.021, 552.023, 559.003, and 559.004.)

Coverage Attestation

By signing below, I attest that the applicant has no other coverage than what is listed in the *Insurance Information* section of this application.

I authorize the program to bill the coverage sources listed for any services provided.

Statement of Release of Information

I authorize release of medical information to the Texas Department of State Health Services as necessary to determine and maintain eligibility of the client and coordinate services.

Acknowledgement

I understand that this application is a legal document and that by signing I am stating from my personal knowledge that the facts in the application are true and correct. I understand that the application will not be accepted if it is incomplete.

If you are approved, you are responsible for maintaining your program eligibility.

X		
	Signature	**Date (mm/dd/yy)**

These two pages show your rights and duties. You must read and understand them.

Your Rights:

- You have the right to know all of the information that we collect about you.
- You have the right to be given this information if you ask for it.
- You have the right to review it.
- You have the right to ask us to correct any thing that is not correct.
- You understand that the website www.dshs.state.tx.us/policy/privacy.shtm will tell you how we will keep your information private.
- You have the right to be treated fairly, equally, and without regard to race, color, creed, religion, national origin, gender, age, political beliefs, or disability.
- You understand that this treatment will go along with state and federal law. If you think you have not been treated fairly and equally, you can call the Office of Civil Rights of the United States Department of Health and Human Services at 1-800-368-1019.
- You understand that what you write on the Program application will not be shared with the Internal Revenue Service (IRS) or the United States Citizenship and Immigration Services (formerly the Immigration and Naturalization Service [INS]).
- You have the right to use the appeals process when you disagree with a decision we make about you.
- You have the right to receive a timely response to your appeals.
- You have the right to two types of appeals: the administrative review and the fair hearing. (See next column).

Administrative Review

This type of appeal is a way for you to tell us the reasons why you think we should change one of our decisions about your case. You must request a review **within 30 days** of the date on the letter that tells you our decision. You must state in your request why you disagree with our decision. Be sure to include any items or proof that you think help to support what you state in the request.

You can ask for a review by sending a fax to (512) 776-7238, or by sending a written request to:

CSHCN Services Program Administrative Review
Health and Human Services Commission
Purchased Health Services Unit, MC 1938
P.O. Box 149347
Austin, Texas 78714-9347

We will send you a letter after we finish our review. The letter will tell you our decision. If you do not agree with that decision, you have a right to request a Fair Hearing.

Fair Hearing

You can request a fair hearing when you disagree with our decision from the administrative review. You must request a hearing **within 20 days** of the date on the letter that tells you our decision from the administrative review. If you do **not** request a hearing within the 20-day period, you will give up your right to the hearing, and our decision from the administrative review will be final.

If you request a hearing, you should state why you disagree with our decision. Be sure to include any items or proof that you think will help to support what you state in the request.

You may represent yourself or have legal counsel or another spokesperson at the hearing. You can ask for a fair hearing by sending a fax to (512) 776-7238, or by sending a written request to:

CSHCN Services Program Fair Hearing
Health and Human Services Commission
Purchased Health Services Unit, MC 1938
P.O. Box 149347
Austin, Texas 78714-9347

Your Duties:

Your duties are the things you must do as a client in our program.
We show you the types of duties you have in the lists below.

About this application:

- You must put only true, correct, and complete information on this application.
- You must answer every question on the application.
- You must not leave out any information that the application asks for.
- You must give us any proof we ask for. We can ask you to give proof of anything that you write on the application.
- You must reapply to our program on time every 12 months, even if you are on the waiting list. "On time" means on or before the date when your eligibility ends.
- You must tell us about any changes in the facts about yourself within 30 days of the change. These facts include your address, phone number, income, health care coverage, and family situation. You must **not** wait until your next application to update these facts if they change.

About the Program rules:

- You understand that our program rules describe **all** of your rights and duties.
- You understand that we will give you a copy of the rules if you ask for one.
- You agree to abide by all of our rules.

About where you live:

- You must intend to continue living in Texas.
- You must not claim to be a resident of another state or country.
- You understand that we cannot pay for services for anyone who comes to Texas just to get health care.

About how to get services:

- You must get services from doctors and others who are part of our program.
  - You can get services from others if you want to, but we cannot pay for those services.

About other insurance you may have:

- You understand that we will only pay for services you get **after** all your other insurance or health care programs have refused to pay for them.
- You understand that state law may allow your insurance benefits to be paid directly to us. In that case, the health insurance company can pay us back directly for any care we paid for.
- You understand that when you sign the Program's Client Application form, you are saying that:
  - we can collect the payments of any health insurance benefits intended for you, and
  - your insurance company can pay your health care providers directly for benefits and services you get through us.
- You agree to pay us back if you ever get money from a lawsuit that pays for services we already paid for.

About money you may owe us:

- You understand that if we overpay you or pay you in error, you **must** pay back any money that you owe us.
- You will pay us within a reasonable time after we tell you that you owe us money.
- You understand that we can take the amount you owe out of any money we pay in future.
- You must pay the money back even if you are no longer in our program or you leave our program.
- You or your estate will pay us any money that you owe in a single lump sum if you are no longer in our program.

CSHCN Services Program Regional and Local Offices

The CSHCN Services Program offers case management services to all applicants at no cost. Case managers help families who are having trouble getting medical services, school services, medical equipment and supplies, and other help they need. Contact the closest health service regional office near you to get case management.

Region 1

1C - Canyon Regional Sub-Office (Canyon)

300 Victory Dr.
WTAMU Station (physical address)
PO Box 60968
WTAMU Station (mailing address)
Canyon, TX 79016
Telephone: 1-806-477-1109 or 1-806-655-7151
Fax: 1-806-655-6448

1L - Lubbock Regional Office

6302 Iola Ave.
Lubbock, TX 79424 -2721
Telephone: 1-806-744-3577 or 1-806-783-6452
Fax: 1-806-783-6455

Region 2

2A - Abilene Office

Telephone: 1-325-795-5869

Region 3

3 - Regional Office (Arlington)

1301 South Bowen Road, Suite 200
Arlington, TX 76013 -2262
Telephone: 1-817-264-4634 or 1-817-264-4619
Fax: 1-817-264-4911

Bonham Office

Telephone: 1-903-486-9258

Granbury Office

Telephone: 1-817-579-2117

Denton Office

Telephone: 1-940-320-8275 or
1-888-456-2770, Ext. 287

Mockingbird Office

Telephone: 1-214-819-6749

Rockwall Office

Telephone: 1-972-772-1780

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Region 4

4/5N - Regional Office (Tyler)
2521 West Front Street
Tyler, TX 75702 -7822
Telephone: 1-903-533-5269
Toll free: 1-877-340-8842
Fax: 1-903-535-7593

Athens Office
708 East Corsicana
Athens, TX 75751
Telephone: 1-903-675-9107
Fax: 1-903-675-3622

Carthage Office
1430 South Adams
Carthage, TX 75633
Telephone: 1-903-693-9322
Toll Free: 1-800-306-0568
Fax: 1-903-694-2316

Gilmer Office
324 Yapaco
Gilmer, TX 75644
Telephone: 1-903-843-3030
Fax: 1-903-843-4264

Henderson Office
700 Zeid Blvd.
Henderson, TX 75652
Telephone: 1-903-655-6256
Toll Free: 1-800-306-0568
Fax: 1-903-655-0104

Linden Office
213 Hwy 8 N
Linden, TX 75563
Telephone: 1-903-756-4807
Fax: 1-903-756-5146

Longview Office
1750 North Eastman Road
Longview, TX 75601 -3347
Telephone: 1-903-232-3221 or 1-903-232-3289
Toll Free: 1-866-327-1364
Fax: 1-903-232-3278

Mineola Office
714 Greenville Hwy
Mineola, TX 75773
Telephone: 1-903-569-8164
Toll Free: 1-866-518-0601
Fax: 1-903-569-6243

Marshall Office
4105 Victory Drive
Marshall, TX 75670
Telephone: 1-903-927-0218
Toll Free: 1-866-327-1364
Fax: 1-903-927-0290

Mount Pleasant Office
1014 North Jefferson
Mount Pleasant, TX 75455
Telephone: 1-903-577-1929 or 1-903-575-1138
Toll Free: 1-866-268-6465
Fax: 1-903-577-8957

Palestine Office
330 E. Spring Street, Suite D
Palestine, TX 75801
Telephone: 1-903-661-6089
Fax: 1-903-729-7034

Paris Office
1460 19th Street NW
Paris, TX 75460
Telephone: 1-903-737-0236
Fax: 1-903-737-0330

Sulphur Springs Office
1400 College, Suite 167
Sulphur Springs, TX 75482
Telephone: 1-903-439-9331
Toll Free: 1-866-518-0601
Fax: 1-903-439-9335

Texarkana Office
3115 South Lake Drive, Suite 120
Texarkana, TX 75501
Telephone: 1-903-791-3229
Fax: 1-903-791-3238

CSHCN Services Program Regional and Local Offices

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Region 5 North

Center Office
912 Nacogdoches
Center, TX 75935
Telephone: 1-936-598-1231
Fax: 1-936-591-0162

Crockett Office
1034 South Fourth Street
Crockett, TX 75835
Telephone: 1-936-544-4734
Fax: 1-936-544-0280

Jasper Office
Jasper-Newton County Public Health District
139 West Lamar
Jasper, TX 75951
Telephone: 1-409-384-6829, Ext. 231
Fax: 1-409-384-7861

Kirbyville Office
314 North Herndon
Kirbyville, TX 75956
Telephone: 1-409-423-7544
Fax: 1-409-423-4027

Livingston Office
410 East Church Street, Suite B
Livingston, TX 77351
Telephone: 1-936-328-8240, Ext. 232
Toll Free: 1-888-851-4748
Fax: 1-936-328-8249

Lufkin Office
1210 South Chestnut
Lufkin, TX 75901
Telephone: 1-936-633-3657, 936-633-3769, or 1-936-633-3730
Toll Free: 1-877-340-8840
Fax: 1-936-633-3667

Nacogdoches Office
2614 N.W. Stallings Drive
Nacogdoches, TX 75964-1255
Telephone: 1-936-569-4918
Fax: 1-936-569-4924

Regions 6 & 5 South

6/5S - Regional Office (Houston)
5425 Polk Avenue, Suite J
Houston, TX 77023 -1497
Telephone: 1-713-767-3111
Fax: 1-713-767-3125

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Region 7

7T - Temple Office

2408 South 37th Street
Temple, TX 76504 -7168
Telephone:
254-771-6774
254-771-6738
Front Desk: 254-778-6744
Toll Free: 1-800-789-2865
Fax: 1-254-778-5490

7A - Austin Office

1601 Rutherford Lane, Suite C-3
Austin, TX 78754 -5119
Telephone:
512-873-6315
254-771-6738
Toll Free: 1-800-789-2865
Fax: 1-512-873-6345

Region 8

8 - San Antonio Office

7430 Louis Pasteur Drive
San Antonio, TX 78229 -4507
Telephone: 1-210-949-2142 or 1-210-949-2155
Fax: 1-210-949-2047

Eagle Pass Office

1593 Veterans Boulevard
Eagle Pass, TX 78852
Telephone: 1-830-758-4254 or 1-830-758-4252
Fax: 1-830-773-4688

Victoria Office

2306 Leary Lane
Victoria, TX 77901
Telephone: 1-361-574-7421
Fax: 1-361-574-7396

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Regions 9 & 10

9/10 - El Paso Office
401 East Franklin, Suite 210
El Paso, TX 79901-1206
Telephone: 1-915-834-7675
Fax: 1-915-834-7808

Midland Office
2301 N Big Spring Street, Suite 300
Midland, TX 79705
Telephone: 1-432-683-9492
Fax: 1-432-684-3932

San Angelo Office
622 South Oakes, Suite H
San Angelo, TX 76903
Telephone: 1-325-659-7853
Fax: 1-915-655-6798

Region 11

11H - Harlingen Office
601 West Sesame Drive
Harlingen, TX 78550 -4040
Telephone: 1-956-423-0130
Fax: 1-956-444-3293

Alice Office
408 N. Flournoy, Suite C
Alice, TX 78332
Telephone: 1-361-660-2263
Fax: 1-361-668-4000

11C - Corpus Christi Office
5155 Flynn Pkwy.
Corpus Christi, TX 78411
Telephone: 1-361-878-3450
Fax: 1-361-883-4414

11L - Laredo Office
1500 Arkansas Avenue, Suite 3
Laredo, TX 78043 -3049
Telephone: 1-956-794-6385
Fax: 1-956-729-8600

11M - McAllen Office
4501 West Business Hwy 83
McAllen, TX 78501 -9907
Telephone: 1-956-971-1373
Fax: 1-956-971-1275

Mercedes Office
202 West 2nd Street
Mercedes, TX 78570
Telephone: 1-956-825-5310
Fax: 1-956-825-5320

Brownsville Office
1000 W. Price Road
Brownsville, TX 78520
Telephone: 1-956-554-5500
Fax: 1-956-554-5581

Rio Grande City Office
608 N. Garza
Rio Grande City, TX 78582
Telephone: 1-956-487-5556
Fax: 1-956-487-8865