Children's Special Health Care Services (CSHCS)

Purpose of the Program

CSHCS increases access to medical treatment and support services related to certain chronic medical conditions that require pediatric specialty treatment. CSHCS also helps to guide families of children and some adults with special needs in getting other needs met that can impact the family.

What does the program do?

CSHCS helps strengthen and support children and youth with special health care needs and their families. Our program helps families pay for medical care and treatment relating to the child's covered condition. Families with insurance get help with costs such as co-pays, deductibles, and sometimes insurance premiums. CSHCS may help families with transportation to and from doctor's appointments. CSHCS also helps guide families through the maze of different health care systems and connect them with other community-based programs and services.

Who is helped by the program?

Every year over 42,000 children and youth receive pediatric specialty treatment and other services through CSHCS. Here are examples of conditions CSHCS may cover:

Diabetes	Cerebral Palsy	Sickle Cell
Epilepsy	Chronic Ear Infections	Cancer
Asthma	Heart Conditions	Lead Poisoning

Children and youth must be under the age of 21 and have a covered medical condition(s) that is chronic and severe enough to need treatment by a pediatric specialist to be eligible. **Sickle Cell Disease, Cystic Fibrosis and Hemophilia** are covered for children and youth in addition to coverage extended for individuals **over the age of 21 years,** therefore all ages may apply with any of these three diagnoses. Families of all incomes can enroll their child, including those with other health insurance.

Where are services located?

CSHCS has a statewide network of pediatric specialists, Children's Hospitals and other providers. CSHCS also offers statewide community based services through the local county health departments.

CSHCS Values

The program is committed to providing services in a family-centered, community-based, coordinated, culturally and linguistically (languages other than English) appropriate manner.

Please complete the form and send back to:

CSHCS- Detroit, 100 Mack Ave- 1st Floor, Detroit, MI 48201

For more information, please contact: Children's Special Health Care Services

Detroit 313-876-4223 or 800-359-3722 * ask for Detroit

cshcsfc@michigan.gov

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Michigan Department of Health and Human Services

Instructions to FAMILY:

- Please complete this form and retain PINK copy for your records.
- Send one WHITE copy to the specialty doctor, hospital, or clinic treating the person who is seeking Children's Special Health Care Services (CSHCS) coverage.

Instructions to PROVIDER:

- Retain WHITE copy for your records.
- **Fax** a copy of this form along with the ***most recent*** comprehensive medical information (**less than 12 months old**) related to the diagnosis(es) requiring specialty care to: **517-335-9491**.

Patient Name			Date of Birth		
Patient Address (number and street –l/c)			CSHCS/ Medicaid ID Number		
City	State	ZIP Code	County		
Parent/ Guardian Name			Parent/ Guardian Phone Number - -		
Parent/ Guardian Address (if different than patient)			City	State	ZIP Code

I authorize _____

(Name of Specialty Doctor, Hospital, or Clinic)

located at _____

(Complete Address of Specialty Doctor, Hospital or Clinic)

to release the most current medical information (from the past 12 months), which may include medical reports, letters from physician specialists, office or hospital inpatient or outpatient summaries that review status of medical problems and ongoing treatment plans, to the Michigan Department of Health and Human Services (MDHHS), Children's Special Health Care Division or their agents for the purposes of determining program eligibility. These records may include any information about Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC); and any other communicable diseases as defined by the MDHHS.

I understand that if I give permission, I have the right to change my mind and revoke it. This must be in writing to you. I understand that if this authorization is required as a condition of demonstrating criteria for eligibility in the CSHCS program and I revoke the authorization, then CSHCS has a right to contest my claim(s). I also understand that I cannot take back any uses or disclosures already made with my permission.

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services or eligibility unless the information is necessary to demonstrate that I meet the criteria required to establish eligibility.

By signing this Authorization, I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal privacy rules. I further understand I may request a copy of this signed authorization.

Unless revoked, this authorization expires 12 months from the date signed.

Signature of Patient, Parent or Legal Guardian	Date Signed
Signature of Witness (any adult over the age of 18)	Date Signed

The Michigan Department of Health and Human Services does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

AUTHORITY: Public Act 368, P.A. of 1978 **COMPLETION:** Is Voluntary

ASSISTED BY CSHCS AT THE DETROIT HEALTH DEPARTMENT