

UTAH DEPARTMENT OF HEALTH
Community and Family Health Services Division
Children with Special Health Care Needs
ABLE PROGRAM
PO Box 144640, Salt Lake City, UT 84114-4640
Phone: 801-584-8552 FAX: 801-584-8562
Toll Free: 1-800-829-8200 (Voice & TDD) 1-800-826-9662

APPLICATION FOR SERVICES

Person to Receive Services:

Name (Last, First Middle): _____ Date of Birth: _____

Address: _____ City: _____ UTAH Zip: _____

County: _____ Home Phone: _____ Work Phone: _____

Sex: **M** **F** Race: _____ Hispanic Pacific Islander

Social Security Number: _____ Language Spoken in the Home: _____

Parent **Guardian** **Spouse** **Other**

Mother's Name (Last, First Middle): _____

Father's Name (Last, First Middle): _____

Address and Phone Number, if different from above:

Address: _____ City: _____ UTAH Zip: _____

Home Phone: _____ Work Phone: _____

Friend or Relative who can reach family:

Name: _____

Address: _____ City: _____ UTAH Zip: _____

Home Phone: _____ Work Phone: _____

Referred by: _____ **Agency:** _____

Address: _____ City: _____ UTAH Zip: _____

Problem, Condition or Reason for Application: _____

Services Requested: _____

Release and Consent:

- I understand that community and Family Health Services (CFHS) collects and shares information with others as necessary to facilitate the mutually agreed upon services and treatment.
- I consent to services and treatment to be provided by CFHS to which is mutually agreed.

Signature: _____ Date: _____

The policy of CFHS is to provide reasonable accommodations to the known disabilities of patients and their families in compliance with the Americans with Disabilities Act.

Utah Department of Health
Community & Family Health Services
Children with Special Health Care Needs
PO Box 144610
Salt Lake City UT 84114-4610

IMPORTANT FINANCIAL NOTICE

Dear Parent or Guardian:

The Department of Health, Children with Special Health Care Needs (CSHCN) Programs will bill families for clinic services using a sliding fee schedule. As in the past, your insurance company and/or Medicaid, if applicable, will be billed for our services. The following policies will apply:

○ Yearly financial updates are required. Bring information on your: income, insurance, Medicaid, and family medical expenses when you come to clinic. If we have not gone over your finances with you this year, then your personal financial responsibility (PFR) will be figured during your appointment. If, however, we have already figured your PFR during the past 12 months, then that PFR may still apply unless your financial situation has changed. Please remember that your PFR may be updated at any time.

○ Community & Family Health Services physicians do not participate with any Blue Cross & Blue Shield health plans. We will file with your insurance, but payments and/or denials may be sent directly to you. Please forward any payments, denials, and/or communications from your insurance to us.

Please Mail to:

Community & Family Health Services
Patient Accounts Dept.
P O Box 142001
Salt Lake City, UT 84114-2001

○ If your insurance company requires pre-authorization, you must contact them prior to clinic visits and obtain a written or verbal referral/pre-authorization or denial form from your doctor. Please bring this information with you to the clinic. If you fail to bring in a pre-authorization/referral or denial for the day of clinic, you may have to pay 100% of your bill.

○ If you have Medicaid coverage, you must bring your current Medicaid card to your clinic visit. If you have Medicaid with an HMO, IHC Access, Intergroup, Med-Utah, or United Med-Choice, you must contact your provider for a referral before your appointment with Children with Special Health Care Needs. Please bring the referral with you to the clinic.

○ Please contact your team resource specialist, Chris Sandoval at 584-8557 if you have any questions concerning these billing policies. If you are calling long distance, you can call our 800 number, 1-800-829-8200 and ask for Children with Special Health Care Needs.

Thank you

3/15/00 jjp

(FOR THOSE WHO HAVE INSURANCE)

KNOW YOUR INSURANCE

Getting the most from your health insurance plan is sometimes confusing and complicated. Your policy explains your specific benefits in detail (if you have a law degree and several hours to study it), but for many of us it's not easy. Yet you must work within the rules of your plan to insure that you collect the benefits you are paying for.

A denial of benefits for Community & Family Health Services is most often due to lack of prior authorization. Health maintenance plans and preferred provider plans have a list of doctors you must use if insurance is to cover the service. To use any doctor not on their list requires a prior authorization. To find out if your plan requires a prior authorization for any services you may need, call the customer service number on the back of your insurance card or ask one of their providers.

If your plan does require prior authorization for outside services, you must first develop a relationship with a physician from the insurance plans preferred provider list. This doctor is your primary care provider and assumes responsibility for your medical care. He/She must authorize any care you need which is outside your preferred provider plan. It isn't necessary to be sick to visit one of these physicians. Make an appointment for a well-child or get acquainted visit. Be sure to inform this doctor of your complete medical history. Once your records are established and your primary care provider is aware of your needs, getting authorizations for necessary care from other sources is usually quite simple.

When you call your doctor's office for a prior authorization, the referral clerk will probably be able to handle this for you. Be sure to have all necessary information ready. You will need to give the clerk the name of your insurance company, the name and address of the specialist you need to visit, and a complete description of the care you hope to receive: doctor, dietician, social worker, blood test, metabolic formula. etc. If you are requesting the authorization well in advance, have the clerk mail it. If there is a question of adequate time for the authorization to be processed before your visit, pick it up and take it with you to your appointment with the specialist.

Preferred provider insurance plans were developed to control spending. At first, you may feel as though they are trying to control you! But once you get to know preferred provider and their staff, you will probably find this is a very efficient and satisfactory way to meet your medical needs.

UTAH DEPARTMENT OF HEALTH
Community & Family Health Services Division
FINANCIAL FORM

Patient's Legal Name _____ Birthdate _____ Soc Sec # _____
Last First MI

Address _____ Phone _____
Street City ST Zip

Parent/Guardian _____ Relationship to Patient _____

1st Insurance _____ Insured _____ Employer _____

Ins Address _____ Policy # _____ Group # _____
Street City ST Zip

2nd Insurance _____ Insured _____ Employer _____

Ins Address _____ Policy # _____ Group # _____
Street City ST Zip

Medicaid # _____ HMO _____

Financial Assistance Available: You may be eligible for financial assistance for services provided by Community & Family Health Services. To help us determine your eligibility for assistance, please complete the following information.

I decline to fill out the section below. I understand that by withholding the information below, I will not be eligible for financial assistant for services provided.

Financial Information (As counted on your income tax) Shaded area for agency use

Number of children..... _____
(If pregnant, include the unborn child)

Total Family Size

Number of adults..... _____
(Including yourself, spouse and any eligible adults)

***Average Gross Monthly Income for Family**

Gross salary (first wage earner)..... \$ _____
(Before Taxes, Social Security, Insurance Premiums, Union Dues)

Gross salary (second wage earner(s))..... \$ _____

Other income: (includes pensions, compensations,
 income from rentals, interest, dividends, alimony or
 child support, public assistance grants, etc..... \$ _____

***Total Gross Monthly Income** \$ _____

****Total Deductions** \$ _____

Total Net Income \$ _____

Monthly Deductions for Family

(Out of pocket)

Medical/Dental Expenses..... \$ _____

Medical/Dental Premiums..... \$ _____

Child Support or Alimony..... \$ _____

Child Day Care Costs..... \$ _____

****Total Deductions..... \$ _____**

Personal	0%	Y	N
Financial	60%		
Responsibility	100%		

Is patient receiving SSI (Supplemental Security Income) Y / N
(If yes, do not add in SSI income)

I authorize insurance, Medicaid or Medicare benefits to be paid to Community & Family Health Services or its authorized agent, and for Community & Family Health Services or its authorized agent to release information to insurance companies, Medicaid and Medicare as necessary to process claims.

I understand that my Financial Responsibility will be calculated based on the information I provided above. I understand that I may be liable for all or a portion of the bill, and that interest may be charged on accounts unpaid 60 days after billing date.

Signatures _____
 Patient, Parent or Guardian

Date _____

 Community & Family Health Services Representative

Date _____

CONSENT TO RELEASE INFORMATION

Utah Department of Health Division of Community and Family Health Services
Children with Special Health Care Needs Bureau
ABLE Program
44 Mario Capecchi Drive, P. O. Box 144640
Salt Lake City, UT 84114-4640

As Parent/Legal Guardian/Self (circle one), I request that records be released regarding the following child:

Name: _____ Date of Birth: _____
Current Address: _____ City: _____
State: _____ Zip: _____ Phone Number: _____

as indicated below:

I consent to the release of information held by _____ to the Utah Department of Health, Children with Special Health Care Needs Bureau. Please send material to:

Children with Special Health Care Needs Bureau
44 North Medical Drive, P. O. Box 144640
Salt Lake City, UT 84114-4640

I consent to the release of information held by the Utah Department of Health, Children with Special Health Care Needs Bureau to: Name: _____

Organization: _____
Address: _____

This release is for the following type of information as checked below:

- | | | |
|--|---|---|
| Medical_____ | School_____ | Community_____ |
| <input type="checkbox"/> Immunization <input type="checkbox"/> Medical | <input type="checkbox"/> Achievement | <input type="checkbox"/> OT/PT |
| <input type="checkbox"/> Admit/Discharge Summary | <input type="checkbox"/> IQ/Psychological | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Newborn Screening Tests | <input type="checkbox"/> Attendance | <input type="checkbox"/> Dental |
| <input type="checkbox"/> Feeding/Nutrition | <input type="checkbox"/> Speech/Language | <input type="checkbox"/> Community Staffing |
| <input type="checkbox"/> Birth/Newborn Records | <input type="checkbox"/> Behavioral | <input type="checkbox"/> Newborn Screening Tests |
| <input type="checkbox"/> Lab/Medical Imaging | <input type="checkbox"/> IEP/IFSP | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> Surgical Reports | | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Developmental | <input type="checkbox"/> Other Explain: | <input type="checkbox"/> Collaborative Consultation |

I understand that I may withdraw this consent to disclose information at any time by notifying you in writing. This consent remains **effective for one year** from the date last signed.

Signature: _____ Relationship to child: _____ Date: _____
Signature: _____ Relationship to child: _____ Date: _____
Signature: _____ Relationship to child: _____ Date: _____
Signature: _____ Relationship to child: _____ Date: _____
Signature: _____ Relationship to child: _____ Date: _____

For questions regarding this request, contact:

Name: Lila Hutchinson
Phone: 801-584-8552
Fax: 801-584-8562

Brief History of Current Concerns

Name _____ Birth Date _____ Age _____ Date _____
Address _____ City _____ State _____ Zip code _____
Parent or Guard name _____: Child in foster care? Adopted) _____ Insurance _____
Phone # _____ Work # _____ Cell # _____ School/PreSch _____ Telephone # _____
District _____ Grade _____ IEP/IFSP _____ 504Plan _____ Other Help _____ Classroom type _____ Academic expectations _____
Teacher/PreSch Tch _____ Resource Teacher _____
Physician's Name _____ Clinic/Office _____ Recent Physical _____ Last
Visit _____ Any Significant Problems? _____
Other MD/Specialist or Therapist _____ telephone # _____ Dentist _____
Other important helpers/friends/ Rate 1-10 (10=most help) _____

How do they help? _____

Referred by: _____

Reason for Referral _____

Brief Medical History (birth, infections, accidents, hospitalizations,)

Past Medications/Herbals _____ Prescribing Physician _____

Current Meds/Dosages _____ Side effects? _____

Child/Activities/Sports/Hobbies/ Rate Interests 1-10 _____

Family Living in Home with ages (circle if having significant concern) _____

Family's special customs and traditions, /cultural preference / ethnic identity//other language in home? _____

Significant Family Medical History _____

Brief Child Developmental History incl growth, nutrition _____

Dates of Significant Past Events: psychological trauma, abuse or neglect?, custody change, substance abuse?, death/loss in family, domestic violence, divorce? etc.) _____

Current **Crisis?** _____ Overall **Family Stress** on a 1-10 (10=most distress) _____ Child Contribution to Stress 1-10 _____ **Job**
Satisfaction 1-10 (10=most satisfied) _____ **Income**-Low End-Middle-Higher End(circle), **Financial Stress** 1-10 (10=most
critical) _____ **Housing** Satisfaction 1-10 _____ **Neighborhood** 1-10 _____ **Family Coping?** 1-10 (10=best coping) _____ **Confidence** that
things will get better 1-10 _____ **Other:** Describe: _____

Previous Evaluations: Developmental Pre-School _____ Early Intervention _____ Agency 1 _____
Services Currently Being Used: Valuing help 1-10 _____
Caseworker/Community Program/ Agencies: Rate helping 1-10. How many agencies? _____

Child Symptoms Home and or School/Pre-Sch Rate Sx (1-10). Sharring Sx in both settings? (Mark B)

Physical

- Pain/ Fatigue _____
- Nutrition/Growth _____
- Physical Features _____
- Recurrent Illness _____
- Sleep/ Toileting _____
- S/H/V (Speech, Hearing, Vision) _____

Adaptive Behavioral

- Temper, Aggression _____
- Impulsivity _____
- Disruptive _____
- Habits/Rituals _____
- School Attendance _____
- Other _____

Emotional

- Fear/Anxiety _____
- Rapid Mood Swings _____
- Depression _____
- Anger _____
- Hyperactive/Attention _____
- Self-esteem _____

Development

- Social/Friends _____
- Aptitude/IQ/Dev Level _____
- Communication/ Language _____
- Attachment/Bonding _____
- Fine/Gross Motor _____
- Self-help Skills _____

School/Pre-Sch Testing, What, When? _____

1-5 scales (fill in for your child with higher number = best function) (If child under 5 apply to Pre Sch experience)

Overall Progress/Achievement: 1-5 ____ School/Pre-Sch Behavior: 1-5 ____ School/Pre-Sch Attendance: 1-5 ____

School Social/Peers: 1-5 ____ Parent-School Relations and Communication 1-5 ____ Cope with School Stress 1-5 ____

People you can depend on at School: _____

Don't forget to bring this form/ school material to your Primary Care provider: (IEP, report cards, testing, sample of work) See Principal Letter under Menu, Contact Us at http://health.utah.gov/able/contactus/fasttrack_counsel.html

High Concern maybe determined by either two highlighted components in each of the following domains, or any combination of twelve.

Child Family School Community

Utah Department Of Health
COMMUNITY AND FAMILY HEALTH SERVICES
CHILDREN WITH SPECIAL HEALTH CARE NEEDS

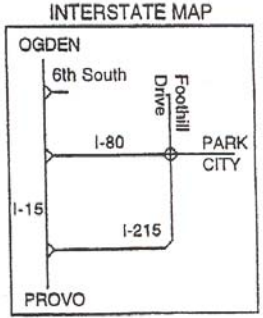
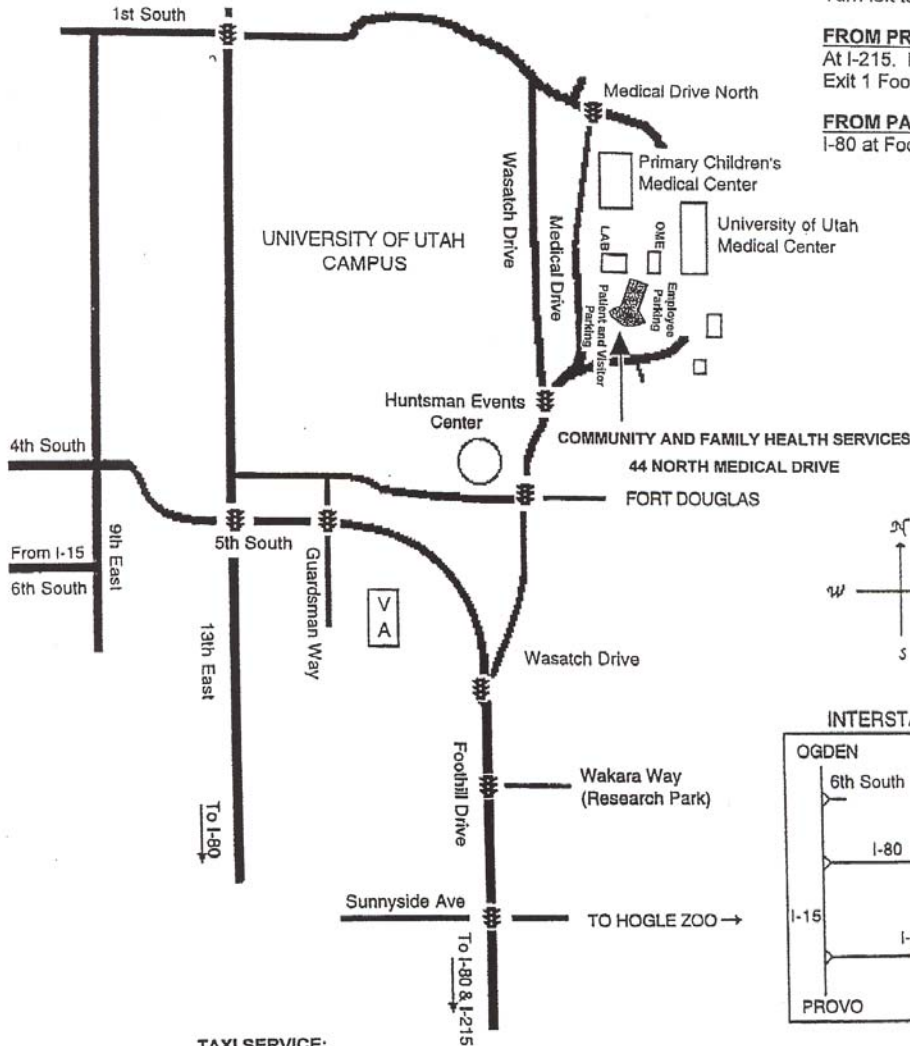
ABLE Program
(584-8552)

* Wasatch Drive and Medical Drive
 have been changed to
 Mario Capecchi Drive.

FROM OGDEN: Exit I-15
 At 6th South Exit.
 Continue to 9th East.
 Turn left to 4th South.

FROM PROVO: Exit I-15
 At I-215. Exit I-215 at
 Exit 1 Foothill Drive.

FROM PARK CITY: Exit
 I-80 at Foothill Drive.



TAXI SERVICE:

City Cab: 363-5014	Utah Medi-van: 466-4454
Handi van: 486-8416	Ute Cab: 359-7788
Midvalley: 562-0100	Wasatch: 2954666
Murray: 328-5704	West Valley: 328-5705
Our Pat: 280-4646	Yellow Cab: 521-2100
South SL: 328-5704	

UTAH TRANSIT AUTHORITY BUS SERVICE:
 Route #3 Third Avenue leaves State Street and 3rd.
 South 15 minutes before and after the hour to
 University Medical Center. Arrives/leaves University
 Medical Center 15 minutes before and after the hour.