SPECIALIZED CARE FOR CHILDREN

APPLICATION FOR CARE COORDINATION

We *partner* with Illinois families and communities to *help* children and youth with special healthcare needs *connect* to services and resources.

How we help you and your child depends on your specific needs and preferences. Our care coordination can support you in the following areas:

- Connect you to specialty care and other health services
- Partner with doctors to keep the health care team informed
- Build a service plan to help with your needs
- Connect you to other services and groups in your community
- Learn about rights, including early intervention or education
- Find answers to your questions
- Help you use your health insurance or All Kids/Medicaid
- Partner with the school to address special health needs
- Learn about diagnosed health conditions
- Advocate if things get in the way of getting care
- Connect you to other youths and parents
- Coordinate care and services

For more information or help completing this application, contact us:

P: (800)322-3722 TTY: (217)785-4728 F: (217) 558-0773

dscc.uic.edu Like us on Facebook

All information on this application will be kept private, unless you provide written permission.

PLEASE PRINT CLEARLY

Child/Youth Information

Legal Name _____ Birthdate ___/___/___
(Last) (First) (Middle) (Month) (Day) (Year)

Street Address _____

City _____ State _____ Zip _____ County _____

Lives in Illinois? ☐ Yes ☐ No
Is a citizen of US? ☐ Yes ☐ No → If no, permanently admitted to US? ☐ Yes ☐ No

Gender: ☐ Male ☐ Female

Race/Ethnicity: *(optional)*
☐ American Indian or Native Alaskan
☐ Asian
☐ Black or African American
☐ Hispanic/Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White

Applying Parent or Legal Guardian *(usually the person filling out the form)*

Legal Name _____
(Last) (First) (Middle)

Relationship: ☐ Father ☐ Mother ☐ Other _____

Phone (___)_____ (___)_____ (___)_____
(Home) (Work) (Cell)

Preferred Phone Number ☐ Home ☐ Work ☐ Cell E-mail Address _____

Best Time to Contact _____

Address: ☐ Check if same as above

Street Address _____

City _____ State _____ Zip _____

Lives in Illinois? ☐ Yes ☐ No
Is a citizen of US? ☐ Yes ☐ No → If no, permanently admitted to US? ☐ Yes ☐ No

What Language Do You Use the Most? ☐ English ☐ Spanish ☐ Other _____

Please Read and Sign

I certify that the information given on this application is correct to the best of my knowledge. I further certify that I am legally entitled to make decisions about and provide for the special medical care needed for which I am submitting this application.

☐ I have received the Notice of Privacy Practices
☐ I have been offered the Notice of Privacy Practices but decline because _____

_____

_____

Signature of Applying Person ***Date***

DSCC NUMBER: _____
OFFICE USE ONLY