UIC UNIVERSITY OF ILLINOIS AT CHICAGO SPECIALIZED CARE for CHILDREN

APPLICATION FOR ASSISTANCE

APPLYING FOR UIC-DSCC HELP

Families tell us, *"Part of the problem of having a child with special needs is finding out what they need, where to get it, and how to pay for it."* For many families, finding needed resources can be difficult.

A care coordination team is ready to work with you to find the help you need. As one parent said, *"The (care coordinators) have always been helpful and a calming voice..."*

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

1-800-322-3722 (Voice) 1-217-785-4728 (TTY)

www.uic.edu/dscc

HOW WE HELP ALL FAMILIES

It is our goal to see if we can find help for you/your child. We will give you information on other programs, groups and resources. Please call us any time with questions regarding possible programs and resources for you/your child.

You can receive our care coordination services at no cost to you. A member of your care coordination team will talk to you about how we can help. We may be able to help you:

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

Remember, once we get this application and signed *Authorization to Release Health Information* forms, we will request medical reports. After the medical reports are received, we will contact you to let you know the outcome of your application.

HOW WE HELP WITH CERTAIN MEDICAL BILLS

We will let you know if you are eligible for help with certain medical bills based upon the proof of income you send in with this application. We may also be able to help with transportation to specialty care appointments. A member of your care coordination team will contact you and send information on how to use Specialized Care for Children financial help. It is important to remember to:

- Talk to us before scheduling any care to see if we can help with payment
- Use your health insurance and/or All Kids/Medicaid
- Remember, if a service occurred in the past month and you want to see if we can help pay for that service, we **must** receive your completed application within thirty (30) days of the date the service was received

APPLICATION CHECKLIST

Before you send this application, use the checklist below to make sure you are sending us everything we need.

- ☐ Signed and dated Certification (Page 3)
- ☐ Attached a copy, front and back, of your insurance card(s) or All Kids/Medicaid Eligibility Letter/Card *(if applicable)*
- ☐ Enclosed copies of proof of income, if you are applying for financial assistance ***(select one)***:
  - ☐ Copy of most current Federal Income Tax Return (Form 1040, 1040A, 1040EZ)

  OR

  - ☐ Copy of most current Federal Income Tax Return (Form 1040, 1040A, 1040EZ) and a copy of wage statements (for two [2] pay periods in a row within two [2] months from the date of this application for each wage earner in the family) if the tax return does not reflect current income

  OR

  - ☐ Copy of wage statements if you are not required to file a Federal Income Tax Return
- ☐ Signed Financial Information Certification (Page 4, if you are applying for financial assistance)
- ☐ Copied this application packet for your records
- ☐ Signed and dated enclosed *Authorization to Release Health Information* forms
- ☐ Recorded the date this application was mailed _____
- ☐ Recorded the date to follow-up with your care coordination team member _____ (thirty [30] days from the date this application was mailed)
- ☐ Detached this page for your records

UIC UNIVERSITY OF ILLINOIS AT CHICAGO SPECIALIZED CARE for CHILDREN

APPLICATION FOR ASSISTANCE

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

PLEASE PRINT CLEARLY

1. Tell Us About You/Your Child

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

Have you/your child received medical treatment under any other name? If yes, _____
(Last) (First) (Middle)

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
☐ Other _____

2. Tell Us About the Applying Parent or Legal Guardian *(usually the person filling out the form)*

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

Relationship: ☐ Father ☐ Mother ☐ Other_____ Birthdate: ___/___/___
(Month) (Day) (Year)

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

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

Best Time to Contact _____ *(Our hours are 8:00 AM to 4:30 PM, Monday through Friday)*

Social Security # ☐☐☐ – ☐☐ – ☐☐☐☐ **OR** Individual Tax ID # ☐☐☐ – ☐☐ – ☐☐☐☐

Address: ☐ Check if same as above

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

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Do You Have Legal Guardianship? ☐ Yes ☐ No, explain _____

(Continue on Page 2)

CASE NUMBER: _____
OFFICE USE ONLY

3. Tell Us About Any Other Parent *(if applicable)*

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

Relationship: ☐ Father ☐ Mother ☐ Other_____ Birthdate: ___ ___ / ___ ___ / ___ ___ ___ ___
(Month) *(Day)* *(Year)*

Phone (____)_____ (____)_____ (____)_____ (____)_____
(Home) *(Work)* *(Cell)* *(Other)*

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

Best Time to Contact _____ *(Our hours are 8:00 AM to 4:30 PM, Monday through Friday)*

Social Security # ☐☐☐ – ☐☐ – ☐☐☐☐ **OR** Individual Tax ID # ☐☐☐ – ☐☐ – ☐☐☐☐

Address: ☐ Check if same as above

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

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Do You Have Legal Guardianship? ☐ Yes ☐ No, explain _____

4. Tell Us About Your/Your Child's Health Issues:

_____

_____

_____

_____

_____

How long have you known about the health issue(s) described above? _____

What kinds of treatments have been needed for these health issue(s) up to now? *(check all that apply)*

☐ Visits to doctor ☐ Hospital stays ☐ Surgery ☐ Other _____

In the past six (6) months, what doctors and hospitals have provided care?

Doctor or Hospital	**City/State**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(Continue on Page 3)

CASE NUMBER: _____
OFFICE USE ONLY

Doctors and hospitals that have provided care continued *(attach additional page if needed)*:

Doctor or Hospital	**City/State**

Are you involved in legal action regarding medical care you/your child received? ☐ **Yes** ☐ **No**

Do you or does your child receive Supplemental Security Income (SSI)? ☐ **Yes** ☐ **No**

If medical care has been provided in the last thirty (30) days, please call us right away to see if we can help pay certain medical bills for this care.

5. Employment Information *(for the person who usually pays medical bills)*

Name of Employee _____ Relationship to You/Your Child _____

Name of Employer _____ Employer Phone Number _____

Employer Address _____ City _____ State _____ Zip _____

6. Health Insurance Information

Check all that apply:

☐ **Not** covered by health insurance or All Kids/Medicaid.

☐ Covered by health insurance policy/policies. **(Send a copy of the front and back of your insurance card.)**

☐ Covered by All Kids/Medicaid. **(Send a copy of your eligibility letter or card from All Kids/Medicaid.)**

7. Please Read and Sign

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

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*

(If you are interested in finding out if we can pay certain medical bills, continue on Page 4)

CASE NUMBER: _____
OFFICE USE ONLY

Financial Application

If you have a current Federal Income Tax Return, you must send it to us. Other proof of income may be needed if your income has changed or if you are not required to file a Federal Income Tax Return. Not sure what to send? Call your Regional Office or 1-800-322-3722 (Voice) or 1-217-785-4728 (TTY).

8. Proof of Income

Does your Federal Income Tax Return (Form 1040, 1040A or 1040EZ) reflect your current income?

- ☐ Yes (Send a copy of the current tax return for each wage earner in the family.) (Go to **Number 9**)
- ☐ No (Continue **below** and complete the application.)

If no, check a box below to tell us what proof of income you are sending based on your financial situation (e.g., job change, reduced work hours, etc.).

- ☐ **Income has changed** - Send a copy of your current Federal Income Tax Return and wage statements (for two [2] pay periods in a row within two [2] months from the date of this application for each wage earner in the family). Describe how your income has changed: _____
- ☐ **Not required to file a Federal Income Tax Return** - Send wage statements (for two [2] pay periods in a row within two [2] months from the date of this application for each wage earner in the family).
- ☐ **Not required to file a Federal Income Tax Return and do not receive wage statements** - List the source and amount of your income. Send a copy of the statement that shows your income (e.g., survivor benefits, alimony, workers' compensation, etc.) with this application: _____
- ☐ **Enrolled in the Illinois Hemophilia Program** - Send a copy of your Illinois Hemophilia Program eligibility Letter. You may also send a current tax form to see if you are eligible for financial help up to two (2) years.

9. Total Family Size

Please list **yourself**, **ALL children** and **any other members of your household** that you financially support (Attach additional sheet if needed).

Name (first, middle initial and last)	**Relationship** (e.g., son, daughter, stepchild, grandparent)	**Birthdate**
	Total Family Size	

10. Financial Information Certification *(please read and sign)*

I certify that the income information I have provided is correct to the best of my knowledge.

I understand that providing false information can result in immediate loss of any financial assistance provided by Specialized Care for Children and legal action to recover any amounts previously paid by Specialized Care for Children.

_____

Signature of Financially Responsible Person *Date*

CASE NUMBER: _____

OFFICE USE ONLY