SPECIALIZED CARE FOR CHILDREN

DSCC PROGRAM APPLICATION

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 healthcare team informed
- Develop a care plan focused on your family's strengths and goals
- Locate community funding opportunities and resources
- Work with schools to address your child's needs
- Find answers to your questions
- Help you maximize your insurance and understand your coverage/benefits
- Access diagnostic testing
- Learn about diagnosed health conditions and treatments
- Assist with transportation for appointments
- Connect you to other youths and parents
- Prepare for the transition to adulthood

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

P: (800) 322-3722 **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

What are your child's health concerns? _____

What kind of help are you looking for from DSCC? _____

Child/Youth Information *(Participant)*

Legal Name _____ Birthdate ____/__ __/__ __ __ __
(Last) (First) (Middle) *(Month) (Day) (Year)*

Street Address _____

City _____ State _____ Zip _____ County _____

Lives in Illinois? ☐ 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 Legally Responsible Adult *(Usually the person filling out the form)*

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

Relationship: ☐ Father ☐ Mother ☐ Legal Guardian ☐ Self (If age 18 or over, married or legally emancipated)

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

Preferred Phone Number ☐ Home ☐ Work ☐ Cell Email Address _____

Best Time to Contact _____

Address: ☐ Check if same as above

Street Address _____

City _____ State _____ Zip _____

What Language Do You Prefer? ☐ 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 Legally Responsible Adult ***Date***

DSCC NUMBER: _____
OFFICE USE ONLY