UNIVERSITY OF ILLINOIS CHICAGO

Division of 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 youth 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

We will keep all information on this application private unless you provide written permission.

PLEASE PRINT CLEARLY

What are your child's health concerns? _____

What kind of help do you need 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

Sex: ☐ Male ☐ Female

Race/Ethnicity: *(optional)*

☐ American Indian or Native Alaskan
☐ Asian/Asian American
☐ Black or African American
☐ Hispanic/Latino
☐ Middle Eastern/North African
☐ Native Hawaiian or Other Pacific Islander
☐ Other
☐ White/European American

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