



**DEPARTMENT OF HEALTH**

Children with Special Health Needs  
P.O. Box 70, Drawer 37  
Burlington VT 05402-0070

Patient ID#	
Household ID#	
Clinic	

**APPLICATION FOR CSHN FINANCIAL ASSISTANCE**

CSHN's Financial Assistance program ***covers the costs of certain products and services not otherwise covered by your insurance***, such as office, clinic, and hospital visits, x-rays or lab tests, as well as prescription and over-the-counter medications, physical and occupational therapy, nutritional services, and supplies. Participation in CSHN's Financial Assistance program is subject to annual deductibles, ranging from \$0 to \$1,200, based on your income and family size.

**Please provide Patient and Parent Information requested below.**

Child/Patient's Information					
	Last name	First Name	Middle Initial	Date of Birth	Social Security Number ➡ We cannot process your application without this information.

Parent's Name(s): \_\_\_\_\_ Telephone: \_\_\_\_\_

Mailing Address				
	Street or Box Number	City/Town	State	ZIP

Patient's Primary Care Physician \_\_\_\_\_

**Instructions for remainder of the application:**

- ➡ Families who have Medicaid or Katie Beckett health insurance do NOT need to complete this form.
- ➡ Families without Medicaid/Dr. Dynasaur coverage who wish to apply for CSHN Financial Assistance are required to complete the entire application.
- ➡ Families who DO NOT WISH TO APPLY FOR CSHN FINANCIAL ASSISTANCE AT THIS TIME do not need to complete this form.
- ➡ The application consists of three (3) pages.

**1. Does the patient have Medicaid or Dr. Dynasaur coverage at this time? (Please check YES or NO.)**

<b>YES</b>	We have Medicaid/Dr. Dynasaur coverage. We understand that we should notify CSHN at once if coverage changes. CSHN will cover after-insurance balances for services authorized by CSHN but not covered by Medicaid/Dr. Dynasaur. <b>If you answered YES to this question, please complete items 5, 6, and 7 and return form to CSHN.</b>
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<b>NO</b>	We do not have Medicaid or Dr. Dynasaur coverage. <b>Please go on to Item 2.</b>
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**2. Do you wish to apply for CSHN Financial Assistance? (Please check YES or NO.)**

<b>YES</b>	Yes, we wish to apply for CSHN Financial Assistance. (Please go on to Item 3.)
<b>NO</b>	No, we do not wish to apply for CSHN Financial Assistance at this time. We understand that we may attend CSHN clinics but that we (and our medical insurance) will be responsible for the cost of tests, treatment, supplies, medications, equipment and other services that may be authorized at clinic. We also understand that we may change our mind and apply for assistance at any time in the future. In the event that we apply later on, we understand that coverage is NOT retroactive. Please complete item 7 before returning this form to CSHN.

**3. Household Income.** (This item is required for families who are applying for Financial Assistance.)

Annual Income:	Please report <i>Adjusted Gross Income</i> from your most recent federal Income Tax form.	\$
OR...	You may calculate your family income by using the worksheet, below. Please check the box at the right if you use the worksheet.	

**Family Income Worksheet**

Type of Income	Who received Income?	Gross Amount	Payment period (weekly, monthly, annually, etc.)	This space for CSHN use only.
Wages				
Unemployment Insurance				
Other Income that you report to the IRS (specify)				

**4. Family Size** (Please complete the Family Size worksheet, below. All families applying for CSHN Financial Assistance are requested to complete this item.)

Family Member	Instruction		Number
Yourself		⇒	1
Spouse	Enter "1" if married or if you are counting an unmarried partner whose income you reported in item 3.	⇒	
Child(ren) under age 21	Enter number of children at home or, if living away from home, those whom you still claim as dependents.	⇒	
Others	Enter number of other people for whom you are financially responsible AND whom you claim as a dependent for tax purposes.	⇒	

**Note: If your family size and income fall within Vermont Medicaid eligibility guidelines, CSHN may request that you apply for Medicaid before we provide CSHN Financial Assistance.**

## INSURANCE INFORMATION

The following items pertain to the CSHN patient's private health insurance coverage. We must have this information in order for us to establish or renew a CSHN Financial Assistance account.

5. If CSHN patient does NOT have health insurance, please check this box and return the form.

6. If CSHN patient DOES have health insurance, please provide the information described below:

### Primary Insurance

- Please submit a copy (front and back) of the patient's *Primary* Insurance Card.
- Please print policy-holder's name as it appears on his or her insurance card.

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- What is your Annual Premium (payments you make) for this coverage? 

\$
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- What is your Deductible for this coverage, if any? 

\$
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- Are the patient's medications covered by this policy?  Yes  No  Not sure

### Secondary Insurance (if patient is covered by more than one health insurance policy):

- Please submit a copy (front and back) of the patient's *Secondary* Insurance Card.
- Please print policy-holder's name as it appears on his or her insurance card.

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- What is your Annual Premium (payments you make) for this coverage? 

\$
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- What is your Deductible for this coverage, if any? 

\$
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- Are the patient's medications covered by this policy?  Yes  No  Not sure

**Note: You may attach copies of insurance cards to this form or you may:**

- Scan and send front and back of card as an e-mail attachment to [Mary.Perrault@state.vt.us](mailto:Mary.Perrault@state.vt.us)
- Stop in at the CSHN office housed with the VT Department of Health in Brattleboro, Burlington, Newport, Rutland, or White River Junction and leave the information with our staff person.

Please return this form and required documentation to CSHN as soon as possible so that we may extend your family's financial assistance account without interruption.

☎ Call 802-863-7338 or 1-800-66-4427 if you have questions. Thank you.

7. **Certification: The information I have provided is accurate to the best of my knowledge. I will provide verification if requested by CSHN.**

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Signature

Date