Michigan Department of Health and Human Services
Children's Special Health Care Services

CSHCS MEDICAL ELIGIBILITY REPORT

Instructions for Form MSA-4114

Purpose:

This form is used to determine if an individual is medically eligible for the Children's Special Health Care Services (CSHCS) program. The condition must require the services of a medical and\or surgical sub-specialist at least annually, as opposed to being managed exclusively by a primary care physician. A current list of covered diagnoses is maintained on the MDHHS website at www.michigan.gov/mdhhs. In addition, some diagnoses must meet severity or chronicity criteria (e.g. asthma).

This form should be completed for the following persons:

- Anyone **UNDER 21** years of age with a potentially eligible condition. Psychiatric, emotional and behavioral disorders, attention deficit disorder, developmental delay, intellectual disability, autism, or other mental health diagnoses are **not** conditions covered by the CSHCS program.
- Anyone, regardless of age, with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia.

Completion Instructions:

- Read this instruction page thoroughly. Then separate attached forms.
- **TYPE** or **PRINT** clearly in INK.
- The **Physician's Signature** (or the Attending Physician if a Hospital) and the **Date Signed** are **REQUIRED**.
- Attach supporting medical documentation.
- If desired, make a photocopy for your records.
- **FAX** the completed form to **the CSHCS Division at 517-335-9491.**

Other Information:

- If this request is approved, the client is medically eligible for the CSHCS program.
- For actual program coverage, the client or the client's family MUST APPLY to join the CSHCS program by completing form **MSA-0737**, APPLICATION FOR CHILDREN'S SPECIAL HEALTH CARE SERVICES.
- If the family does NOT receive an application after notification of approval, call **1-800-359-3722**.

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 (TTY 1-866-501-5656).
Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono **1-800-642-3195** (TTY 1-866-501-5656)
Arabic: 1-800-642-3195 (TTY 1-866-501-5656)

إذا كان لديكم أيّ سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ١-٨٠٠-٦٤٢-٣١٩٥

AUTHORITY: Title V of the Social Security Act
COMPLETION: Completion is voluntary, but is required if coverage under the Children's Special Health Care Services program is desired.

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MSA-4114 (05/15) Previous editions may be used

Michigan Department of Health and Human Services
Children's Special Health Care Services (CSHCS)

MEDICAL ELIGIBILITY REPORT

CLIENT INFORMATION:

CLIENT'S Name (Last, First, Middle)			Date of Birth	Sex ☐ **MALE** ☐ **FEMALE**
CLIENT'S Address (Number, Apt. No., Lot No.)			Social Security Number	HOME Phone Number
City	State	ZIP Code	County	WORK Phone Number
Does client have other health insurance? ☐ **NO** ☐ **YES** (Co. Name):			Is client enrolled in Medicaid? ☐ **NO** ☐ **YES** (Medicaid ID No.):	

Racial/ Ethnic Heritage (Check all that apply) (You are not required to complete this information.)
☐ Alaska Native ☐ American Indian ☐ Arabic ☐ Asian ☐ African American/Black ☐ Hispanic or Latino
☐ Caucasian/White ☐ Multi-racial/Ethnic ☐ Native Hawaiian/Other Pacific Islander ☐ Other:

PARENT(S) OR LEGALLY RESPONSIBLE PARTY INFORMATION: (Check appropriate boxes and complete information.)

☐ FATHER or ☐ LEGALLY RESPONSIBLE PARTY Name			☐ MOTHER or ☐ LEGALLY RESPONSIBLE PARTY Name		
Street Address (if different from client's)			Street Address (if different from client's)		
City	State	ZIP Code	City	State	ZIP Code
Social Security Number	Relationship to Client		Social Security Number	Relationship to Client	
HOME Phone Number	WORK Phone Number		HOME Phone Number	WORK Phone Number	

CLIENT MEDICAL NEEDS INFORMATION:

DIAGNOSIS *(If Newborn, give birth weight)* **Primary:**	**Other:**	
SEVERITY/COMPLICATIONS/CHRONICITY		
HISTORY		
TREATMENT PLAN (Include names of specialists involved, and any special needs such as surgery, medications, supplies, therapies, equipment)		
What care will this client need? ☐ **HOSPITAL** ☐ **HOME CARE** ☐ **Other** (explain) -		Requested Coverage Begin Date
PROGNOSIS:		

HOSPITAL Name			Hospital Case Record Number
Hospital Contact Person (Name and Title)			Hospital Phone Number
PHYSICIAN'S Name (Print)			Physician's Phone Number
Physician's Address (Number and Street)			Physician's Signature ***(REQUIRED)*** / Date Signed
City	State	ZIP Code	

For CSHCS Use Only

☐ **APPROVED** - **The client must now complete enrollment process for coverage.** This client is **medically eligible** for the CSHCS Program for diagnosis code(s): _____

☐ **DISAPPROVED** - This client is **NOT** medically eligible for the CSHCS Program. Reason: _____

☐ Eligible for diagnostic evaluation at: _____

_____

☐ Pending / Other:

CSHCS Signature Date

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