

CSHCN Services Program Physician/Dentist Assessment Form Instructions

Instrucciones para el Formulario de Evaluación del Médico / Dentista

(For Application to CSHCN Services Program / Parte de la solicitud al Programa de Servicios CSHCN)

Thank you for helping this family to apply for benefits from the Children with Special Health Care Needs (CSHCN) Services Program. The Physician/Dentist Assessment Form (PAF) is a key part of the application process. The PAF is a two-page form with a block that identifies the applicant, followed by six other short sections that you need to complete about the applicant. Section 7 is for information about you. Please fill in the applicant's identifying information and then go on to section 1.

1) DIAGNOSIS AND EVALUATION SERVICES (screening exam):

If further examinations or tests are not needed, please check the "No" box. Do not leave this section blank. It will slow the application approval process.

If you need to do further examinations or tests to determine if the applicant meets the CSHCN Services Program's "medical certification definition" (see section 2), you must check the "Yes" box and complete **all** of section 1.

Please note that whenever the CSHCN Services Program has a waiting list, the Program cannot pay for diagnosis and evaluation services for new applicants. To find out if the Program currently has a waiting list, call 1-800-252-8023.

2) MEDICAL CERTIFICATION DEFINITION AND DIAGNOSES:

Please pay particular attention to this section. It contains the Program's definition of a child with special health care needs. You must certify whether the applicant does or does not meet either definition A or B.

The primary diagnosis must be a chronic illness or disability with a physical manifestation that affects the applicant and also meets the Program's definition. The form has spaces to add as many as three additional diagnoses.

Please ensure that the primary diagnosis is completed to the highest level of specificity (4 or 5 digits). Forms that are not filled out to their highest level will not be accepted by the CSHCN Services Program.

3) QUESTIONS FOR INITIAL APPLICATION TO THE CSHCN SERVICES PROGRAM:

Complete section 3 only if this is the first time the applicant has ever applied to the CSHCN Services Program.

4) DETERMINATION OF URGENT NEED FOR SERVICES:

This section is **very important**, especially when the CSHCN Services Program has a waiting list. Complete this section thoroughly. It has three parts.

Your answers to section 4 help the Program's physicians determine which children need health care services most urgently. This information is a factor in determining the order in which to remove clients from the waiting list whenever available funds make it possible to do so.

If you answer "Yes" to 4A or 4B, you must provide an explanation. Use the space on the form or attach additional sheets if needed.

When answering 4A, please base your answer on what would happen if the applicant had no resources to pay for health care.

5) FUNCTIONAL NEEDS:

The Texas Legislature requires the CSHCN Services Program to collect this information. Please check **all** appropriate boxes.

6) SERVICES NEEDED:

Please talk with the family and then check the blocks for any and all services the applicant may require. This information will help the CSHCN Services Program plan for effective services now and in the future. It will not affect the applicant's eligibility for services.

7) PHYSICIAN/DENTIST DATA:

Section 7 requires the signature of the physician or dentist AND must be filled out completely.

In order to process the application, the doctor (M.D., D.O., D.D.S., or D.M.D.) must sign and date the form. It cannot be signed by a nurse or physician's assistant. The Program must also have your Provider ID number. Phone numbers are especially important.

Thank you again for all you do to help the clients and families of the CSHCN Services Program!