Case Number

Effective Date

Closed Date:

CSHCN	Prenatal

NEVADA STATE HEALTH DIVISION

BUREAU OF FAMILY HEALTH SERVICES

3427 Goni Road, Suite 108
Carson City, NV 89706
Phone: 775-684-4285 Fax: 775-684-4245

Family Notified ________
ID Card Sent ___________
EDC: ____________________
Delivered: ______________

New ☐
Update ☐
ReOpen ☐

Other Children in CSHCN
____
____
____

Referred to:	UP: ☐	Medicaid: ☐	SSI: ☐	Child supp: ☐	SCC: ☐	Spec. Clinic
Date referred:	________	________	________	________	________	________
Date approved:	________	________	________	________	________	________

DO NOT WRITE IN SHADED AREAS

Client's Name (Last, First, M.I.) M ☐ F ☐ Birthdate Age SS No:

Client's Address: County:

Client Lives With: Both Parents ☐ Mother ☐ Father ☐ Self ☐ Spouse/Partner ☐

Ethnic Background: Cauc. ☐ Black ☐ Amer. Ind. ☐ Span. Orig. ☐ Asian/PI. ☐ Other ☐

Home Phone:
Work, Father/Spouse:
Work, Mother/Client:
Message Phone:

MARITAL STATUS/PARENTS/CLIENT:

Mother: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow(ed) ☐

Father: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow(ed) ☐

Client: Married ☐ Single ☐ Divorced: ☐ Separated ☐ Widow(ed) ☐

CUSTODY STATUS: **Physical Custodian:** Mother ☐ Father ☐ Joint ☐ **Legal Custodian:** Mother ☐ Father ☐ Joint ☐

HEALTH INSURANCE: DEPENDENT COVERAGE: Yes ☐ No ☐

Policy Holder:	Insurance Company Name	Company Address	Policy Group ID No.	Effective Date

Medical Information	Last Seen	Address	Provider #	Rec.Req. Yes	Rec.Req. No	Med.Home Yes	Med.Home No
Family Physician/Clinic							
Specialist *(Client Referred to)*							
Specialist *(Client Referred to)*							
Hospital *(Client Previously Admitted to)*							

Condition for which referral is made: 1) Describe nature of physical handicaps: 2) Give pertinent medical history including resume of care and dates; 3) Give the services providers are requesting at this time.

____

____

____

PHYSICIANS DIAGNOSIS	Pres.	Est.	ICDA Code
1.			
2.			
3.			
4.			

Date received

INCOME:

HOUSEHOLD COMPOSITION: Include all income into the household.

Relationship	List full name	DOB	Soc. Sec. #	*Gross annual Income	How Often Paid
1. Client				$	
2. Mother				$	
3. Father/husband				$	
4.					
5.					
6.					
7.					
8.					

*Fill in order below

Employer and address: Occupation:

1. ____________________

2. ____________________

3. ____________________

OTHER INCOME RESOURCES WITHIN FAMILY:
(i.e., SSI, child support, disability, tips, etc.)

____

____

GROSS LIQUID ASSETS:
(Savings, stocks, bonds, IRA's, 401K's, etc.)

____

____

NUMBER DEPENDENT ON INCOME ________

TOTAL RESOURCES: $

Supporting documents attached

ABSENT PARENT'S NAME: FATHER/MOTHER OF CLIENT ____________________

COMPLETE ADDRESS ____________________

FATHER OF UNBORN: ____________________

COMPLETE ADDRESS ____________________

OTHER PERTINENT INFORMATION *(Use additional sheet if necessary):*

____

____

____

CERTIFICATION AGREEMENT

I certify I have read this application for Family Health Services Assistance (or had it read to me) and I understand the information required. I understand that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State Laws.

____________________ Signature of Applicant/Client

____________________ Date

****Yearly Update Is Required to Continue Eligibility**

NOTICE TO APPLICANTS: You have the right of appeal should there be a substantial disagreement with any determination made as the result of the application regarding FHS financial support or your share of the cost of services.