State of Idaho
Department of Health and Welfare (DHW)

HW-0958
Rev. (1/95)

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO DHW FOR DISABILITY DETERMINATION

COMPLETED BY DHW

Client Name: _____ SSN: _____

DHW Case Number: _____

An original of this form is required for each separate source

COMPLETED BY SOURCE ONLY (NOT Completed by Client or Client Representative) – Please Print, Type, or Write Clearly

Name and Address of Source (Include Zip Code)	Relationship to Client

INFORMATION ABOUT CLIENT

Name and Address (*If known*) at Time Client Had Contact with Source (*Include Zip Code*)	Date of Birth	Client I.D. Number (*If known and different than SSN*) (*Clinic/Patient No.*)

Approximate Dates of Client Contact with Source (*e.g. dates of hospital admission, treatment, discharge, etc.*)

TO BE COMPLETED BY CLIENT OR PERSON AUTHORIZED TO ACT FOR CLIENT

GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF SOCIAL SECURITY AND MEDICAID LAWS, THE PUBLIC HEALTH SERVICE ACT, SECTION 523 AND 527, AND TITLE 38 U.S.C. VETERANS BENEFITS, SECTION 4132.

I hereby authorize the above-named source to release or disclose to the Department of Health and Welfare, the State Disability Determinations Unit, or the Social Security Administration the following information for the periods identified above:

1) All medical records or other information regarding my treatment, hospitalization and/or outpatient care for my condition, including psychological or psychiatric impairment, drug abuse, and/or alcoholism, or sickle cell anemia, or Acquired Immunodeficiency Syndrome (AIDS), or tests for an infection with Human Immunodeficiency Virus (HIV);

2) Information about how my impairment affects my ability to complete tasks and activities of daily living;

3) Information about how my condition affected my ability to work.

I understand that this authorization, except for action already taken, may be voided by me at any time. If I do not void this authorization, it will automatically end when a final decision is made on my application. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

READ IMPORTANT INFORMATION ON REVERSE BEFORE SIGNING FORM BELOW

Signature of Client or Person Authorized to Act for Client	Relationship to Client	Date
Street Address		Telephone Number
City	State	Zip Code

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by DHW, but without it the source might not honor this authorization.

Signature of Witness	Street Address	
City	State	Zip Code

IDAHO DEPARTMENT OF HEALTH & WELFARE

HEALTH COVERAGE ASSISTANCE

Medicaid Application for Child with a Disability

Katie Beckett

Servicios de intérpete o communicación están disponsible al su pedir. El uso de estos servicios se ofrecen gratis y no afectarà la decisión de su caso.

GENERAL INFORMATION

Required Proof: To speed processing time, you need to provide proof of specific items pertaining to your child's situation. You must provide proof of your child's income, such as Social Security award letters, verification of child support received for the child and any other types of income. You may also need to provide proof of your child's citizenship and identity (original or certified documents only). The Department of Health and Welfare (DHW) also needs documentation of the value of the items your child owns, such as checking or savings accounts, trusts, certificates of deposit, savings bonds or any other type of real or personal property belonging to your child. You may be required to share in the cost of your child's care. Cost is determined by your family's size and income. You may be asked to provide proof of your family income.

Application Date: The application date is the date DHW receives a completed signed "Medicaid Application for a Child with a Disability." If your child is found eligible for Medicaid, benefits start the first day of the application month. Benefits can be backdated up to three months prior to the application date if your child would have been eligible if an application would have been filed.

Idaho Medicaid Plan Choice: If approved for Medicaid, your child will be automatically enrolled in the Medicaid Enhanced Plan. The Medicaid Enhanced Plan provides complete health, prevention, wellness benefits and additional benefits that may be required by your child. You may choose NOT to enroll in the plan that meets your child's health needs. You may choose to enroll in Standard Medicaid instead. Standard Medicaid does not include prescription drugs, certain prevention and wellness benefits, therapists, dental services, vision services, and other services. If you do not want to enroll your child in the benefit plan that meets their health needs, you must inform your Self-Reliance worker.

Healthy Connections: Healthy Connections is a mandatory Primary Care Case Management program for Idaho Medicaid. Children participating in Medicaid must enroll in Healthy Connections, unless they qualify for an exemption, such as having a current relationship with a doctor that is not participating in Healthy Connections. Enrollment means you choose one doctor or clinic who will guide your child's healthcare. Please list the doctor or clinic you choose for your child in the CLINIC/DOCTOR box.

This application will be considered without regard to race, color, sex, age, disability, religion, national origin or political belief.

Tell Us Who You Are

Child's Name (First, Middle, Last)		DOB		SSN
Father's Name (First, Last)	DOB	SSN		Monthly Income (before taxes)
Mother's Name (First, Last)	DOB	SSN		Monthly Income (before taxes)
Does the child live with both natural parents	☐ Yes ☐ No	Legal Guardian's Name (First, Last)		
Street Address		City	State/Zip	Phone
Is the child a U.S. citizen or national?	☐ Yes ☐ No	If no, Place of Birth		Alien ID Number
Clinic/Doctor Name (First, Last)		Phone Number		

Would you like Healthy Connections to choose a doctor for you? ☐ Yes ☐ No Is the child covered by health insurance? ☐ Yes ☐ No

Does the child have any unpaid medical expenses from the past three months? ☐ Yes ☐ No

For Office Use Only

Received by Mail _____ **Date Received** _____ **Case #** _____

HW0437 (Revised 06/2009)

Tell Us About Your Household

Provide information about every household member living with the child.

Name	Relationship	Date of Birth

Child's Resources

List if the child receives any of the following income:			List if the child has any of the following resources:	
Type	Amount	How Often?	Type	Amount
Social Security			Savings/Checking Account/Cash	
Child Support			Stocks/Bonds/Certificate(s) of Deposit	
Interest Income			Trust	
Trust Income			Real Property	
Other:			Other:	

Assignment of Medical Support Rights: I understand that Idaho Law (Title 56-209b, Idaho Code) assigns all rights to medical support and third party liability to pay medical expenses of all Medicaid recipients to the State of Idaho. I understand that I must identify liable third party parties for medical insurance coverage of the applicant child, such as insurance companies, and to turn any payments received from those parties over to the Department. I understand that the State of Idaho (Child Support Services) has limited Power of Attorney to receive, endorse, negotiate, and distribute any monies for medical support and for medical expenses paid by a third party. I understand that the financially responsible adult(s) will be treated as a third party resource.

Social Security Number Requirement/Computer Cross Checking: A Social Security Number (SSN) or application for a SSN is required for all persons. The SSN is required by Public Law for Medical Assistance. The SSN will be used throughout the year for computer matching with the Internal Revenue Service (IRS), Department of Labor, the Social Security Administration, and other agencies regarding income and assets. Information gathered from other agencies will be used to make sure your household is eligible for benefits; Wages reported by your employer(s) to the Department of Labor will be checked against wage information you report to your Worker. Criminal, civil or administrative actions against persons incorrectly receiving benefits may result.

Non-Discrimination: If you believe the Department had practiced discrimination because of race, color, age, sex, handicap, national origin, religious creed, or political belief, you can file a complaint with:

Department of Health and Welfare
Civil Rights Affirmative Action Section
P.O. Box 83720
Boise, Idaho 83720-0036

Before you sign, go back and check that each item has been answered accurately. I understand that my signature below means:

- The statements of fact provided on this form are subject to verification and investigation and my signature constitutes authorization for these investigations by Federal, State and Local officials to the extent it applies to the applicant child's eligibility for public assistance; and
- The statements of fact I have made on this application are true and correct; and
- I understand my reporting requirements which have been thoroughly explained to me; and
- I understand my rights and responsibilities and they have been explained to me.
- I will cooperate with Program Evaluation if my case is selected for review; and
- I swear the statements on this application are true and correct.

Signature

Under penalty of perjury, I swear or affirm the information I provide is true and complete.

Signature _____ Date _____

Signature and phone number of interpreter _____ Date _____

HOME CARE FOR CERTAIN DISABLED CHILDREN
"KATIE BECKETT"
CHILD INFORMATION FORM

Child Information

Last Name: _____ First Name: _____ Date of Birth: _____

SSN: _____ Medicaid Number: _____ Sex: ☐ M ☐ F

Address: _____ City: _____ State/Zip: _____ Phone: _____

Physician(s): _____ Phone (1): _____ Phone (2): _____

Emergency Name: _____ Relationship: _____

Address: _____ City: _____ State/Zip: _____ Phone: _____

Hospital of Birth: _____ Insurance: _____

School (List schools attended over the past 2 years):

Family Information

	Name	Occupation	Lives with child?
Father:			☐ Yes ☐ No
Mother:			☐ Yes ☐ No
Step-Father:			☐ Yes ☐ No
Step-Mother:			☐ Yes ☐ No

Sibling Name (In Birth Order)	Birth Date	Lives with child?	Any Medical or Developmental Concerns?
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Child's Medical Information

Primary Diagnosis:		When Made:	
Second Diagnosis:		When Made:	
Third Diagnosis:		When Made:	

Where and what medical/psychological help have you sought since the diagnosis?

Child's Medical Information

Has your child ever been hospitalized or operated on? ☐ Yes ☐ No If yes, please describe:

Has your child ever had a serious illness? ☐ Yes ☐ No If yes, please describe:

Does your child have problems with seeing? ☐ Yes ☐ No If yes, please describe:

Does your child have problems with ears / hearing? ☐ Yes ☐ No If yes, please describe:

Has your child ever had a convulsion or seizure? ☐ Yes ☐ No

Is your child taking medication for seizures? ☐ Yes ☐ No

Is your child taking other medications regularly? ☐ Yes ☐ No If yes, please list the medications:

Child's Functional Information

Activities of Daily Living

Activity	Independent	Some Assistance	Moderate Asst.	Extensive Asst.	Total Care
Bathing	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐
Grooming	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐

Elimination	Voluntary (trained)	Occasionally Involuntary	Frequently Involuntary	Involuntary
Bladder	☐	☐	☐	☐
Bowel	☐	☐	☐	☐

Ambulation / Mobility	Independent ☐	Needs Assistance ☐
Assistive Devices	☐ Braces ☐ Crutches ☐ Walker ☐ Wheel Chair: ☐ Manual ☐ Electric	

Sensory Problems	No Problem	Minimal Problem	Moderate Problem	Maximum Problem
Speech	☐	☐	☐	☐
Hearing	☐	☐	☐	☐
Sight	☐	☐	☐	☐
Motor Skills	☐	☐	☐	☐

Child's Functional Information				
Psycho/Social	No Problem	Sometimes	Often	Always
Confused	☐	☐	☐	☐
Disoriented	☐	☐	☐	☐
Anxious	☐	☐	☐	☐
Wanders	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Socially Withdrawn	☐	☐	☐	☐
Depressed	☐	☐	☐	☐
Verbally Abusive	☐	☐	☐	☐
Physically Abusive	☐	☐	☐	☐
*Safety of Self	☐	☐	☐	☐
*Safety of Others	☐	☐	☐	☐
*Please Describe:				

Is your child able to initiate help for personal or other problems? ☐ Yes ☐ No

If you were unable to care for your child, do you feel he/she would qualify for nursing home care or ICF / MR (intermediate care for the mentally retarded)? ☐ Yes ☐ No

Please add anything else you feel would assist in making this decision.

Services Needed

Information provided in this part of the form will help the nurse determine how much the child's in-home medical care will cost Medicaid.

Medical Services

Receive	Need	Type of Service	How Often	Where
☐	☐	Service Coordination		
☐	☐	Home Health Nurse		
☐	☐	Physical Therapy		
☐	☐	Occupational Therapy		
☐	☐	Speech Therapy		
☐	☐	Developmental Therapy		
☐	☐	Psycho / Social Rehabilitation		
☐	☐	Mental Health Services		
☐	☐			
☐	☐			

Transportation If you have transportation costs for travel to doctor or therapy appointments, approximately how many miles do you travel per month? _____ Where? _____

Medical Supplies

☐ Dressing Supplies. List items used:

☐ Incontinence Supplies (diapers, attends, catheter / colostomy supplies). List items used:

☐ Oxygen Type: ☐ Cylinders ☐ Portable ☐ Concentrator

☐ Other Supplies. List items used:

Medical Equipment: Please indicate medical equipment you have, or will need in the near future.

Have	Need	Type
☐	☐	Wheel Chair Manual ☐ Electric ☐
☐	☐	Hospital Bed
☐	☐	Hoyer Lift
☐	☐	Walker
☐	☐	Bath Bench
☐	☐	Commode
☐	☐	
☐	☐	

Completed by: _____ Date: _____