CHILDREN'S SPECIAL HEALTH AND DENTAL SERVICES ANNUAL UPDATE FORM

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

Check Program(s) Client is Enrolled in: ☐ **CSH** ☐ **DENTAL** **Case #**_____ **Tier Level: 1 2 3 (Circle)**
County_____ **Month Annual Due**_____

PROVIDER(S)/DIAGNOSIS (ES)

THIS SECTION IS COMPLETED YEARLY. In the MD/DX column, indicate current Primary/Medical Home [PMH], Specialty Provider(s) [SP] or Diagnosis (es) [DX]. Choose Provider Type Code (listed below). If adding a new Specialty Provider(s) and/or diagnosis (es), request Medical Record(s) and forward to CSH.

MD/DX (PMH, SP or DX)	PROVIDER'S FULL NAME, Address and Phone Number	Provider Type Code	Date of Last Appointment	Date of Next Appointment

Provider Type Codes:

1. Audiologist	4. Endocrinologist	7. Geneticist	10. Orthodontist	13. Pulmonologist	16. Physical Therapist
2. Cardiologist	5. Speech Therapist	8. Neurologist	11. Orthopaedist	14. Urologist	17. Surgeon - What Type?
3. Dentist	6. Gastroenterologist	9. Ophthalmologist	12. Pediatrician	15. ENT	18. Other:

**SHADED AREA MUST BE COMPLETED*

Record any changes in the appropriate areas below.

CHANGE IN DEMOGRAPHIC INFORMATION

Mailing Address: _____
(Street or PO Box) (City) (Zip)

Physical Address: _____
(House Number and Street) (City) (Zip)

Home Phone #: _____ Work Phone #: _____

CHILDREN'S SPECIAL HEALTH AND DENTAL SERVICES ANNUAL UPDATE FORM (cont)

CHANGE IN HOUSEHOLD COMPOSITION

This includes members who have left the family or have begun living with the family in the last year. (Clients, parents, stepparents or legal guardians and all minor children or dependent adults who make up this family.):

#	Name (Last, First, Mi)	Birth Date	M/F	Relationship to Client	✓ If on CSH or DHS	Note whether to add new member or delete a family member.
1						
2						
3						
4						
5						
6						

CHANGE IN MARITAL STATUS

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

CHANGE IN INSURANCE INFORMATION

Attach a copy of insurance card and/or Kid Care (Medicaid).
If parent who is not living in the home is required to carry health insurance *or* assist with medical bills for client, please note **name** and **address of absent parent** and insurance company: _____

Insurance	Name of Company	Cover Condition	Policy Number Family Member Holding Policy	Deductible & Co-Pay	Premium Paid
Primary		☐ Yes ☐ No			
Secondary		☐ Yes ☐ No			
Dental		☐ Yes ☐ No			
Orthodontic		☐ Yes ☐ No			
Equality Care (Medicaid) **KidCare Chip** (Blue Cross)	ELIGIBILITY DATE: _____	CLIENT"S NUMBER: _____			

**SHADED AREA MUST BE COMPLETED*

Other Changes or Comments: _____

_____

_____

_____

Care Coordinator's Signature County Date

CSH 10

8/11/06
CS