CYSHCN SERVICES REQUEST FORM

Children and Youth with Special Health Care Needs

Name:_____ **DOB:**_____ **Birth Sex:** ☐ Male ☐ Female ☐ Unknown Birth Sex

Parent/Guardian Name:_____

Primary Language:_____ **Phone:**_____

Address:_____
Number **Street**

_____ **County:**_____
City **State** **Zip**

Diagnosis(es)/ICD code(s):_____

Services Requested:

☐ **Hearing-** attach most recent audiology report, audiogram, & Medical Clearance (if requesting Hearing Aids, Cochlear Implants, or Bone Anchored Hearing Aids [BAHA])

☐ **Orthodontia-** attach Orthodontic Program Plan of Care, documentation of craniofacial anomaly, & pictures. Indicate Limited or Comprehensive requested below:

- ☐ **Limited Treatment**
- ☐ **Comprehensive Treatment**

☐ **Special Formula-** attach documentation of diagnosis & formula prescription(s)

☐ **CRS (Children's Rehabilitative Services)-** attach documentation of diagnosis, prescription(s), & most recent clinical note.

☐ **Sickle Cell-** attach documentation of diagnosis

☐ **Hemophilia-** attach documentation of diagnosis & current factor prescription(s)

☐ **Care Coordination-** list needs: _____

Insurance(s):

☐ **Medicaid** **Plan**_____ #_____

☐ **Private** **Plan**_____ #_____

☐ **None**

Agency or Practice Making Referral_____

Name of Person Referring_____

Phone #_____ **Date**_____

Mail or Fax completed form to the CYSHCN regional office covering the client's county of residence (see reverse for contact information)

Referral Disposition by CYSHCN Staff:

S.C. Department of Health and Environmental Control
2600 Bull Street, Columbia, SC 29201 (803) 898-3432 www.scdhec.gov

CYSHCN Regional Offices

Upstate Region CYSHCN- Greenville, Spartanburg, Anderson, Greenwood, Laurens, Pickens, Oconee, Cherokee, Union, Abbeville, McCormick

Greenville County Health Department
352 Halton Road
Greenville, SC 29607
Phone # (864) 372-3065 or (864) 372-3063
Fax # (864) 282-4394

Midlands Region CYSHCN- Richland, Lexington, Aiken, Barnwell, Edgefield, Saluda, Newberry, Fairfield, Kershaw, Lancaster, Chester, York

Richland County Health Department
2000 Hampton Street
Columbia, SC 29204
Phone # (803) 576-2800
Fax # (803) 576-2820

Pee Dee Region CYSHCN- Florence, Horry, Georgetown, Williamsburg, Clarendon, Sumter, Lee, Darlington, Chesterfield, Marlboro, Dillon, Marion

Florence County Health Department
145 E. Cheves Street
Florence, SC 29506
Phone # (843) 673-6607
Fax # (843) 673-6670
Or
Horry County Health Department
1931 Industrial Park Road
Conway, SC 29526
Phone # (843) 915-8806
Fax # (843) 915-6506

Lowcountry Region CYSHCN- Charleston, Beaufort, Jasper, Hampton, Allendale, Bamberg, Colleton, Dorchester, Orangeburg, Berkeley, Calhoun

Charleston County Health Department
3685 Rivers Ave. Suite 201
North Charleston, SC 29405
Phone # (843) 953-4514 or (843) 953-1257
Fax # (843) 953-1276

Instructions for completing the DHEC 4290
(CYSHCN Services Request Form)

PURPOSE

This form is used by outside providers to request/refer individuals to the CYSHCN Program.

ITEM-by-ITEM INSTRUCTIONS

1. **Person submitting the request will:**
    a. **Enter the name of the individual being referred;**
    b. **Enter the date of birth of the individual being referred;**
    c. **Add the birth sex of the individual being referred;**
    d. **Enter the parent's/guardian's name of the individual being referred;**
    e. **Enter the primary language spoken by the individual and/or family;**
    f. **Enter the primary phone number for the individual or family;**
    g. **Enter the diagnosis(es)/ICD code(s) of the individual being referred;**
    h. **Enter the address of the individual being referred, including county;**
    i. **Select the services requested via checking the appropriate box;**
    j. **Select the appropriate insurance coverage for the referred individual, and enter the type of insurance and plan/member ID if applicable;**
    k. **Enter the name of the Agency providing the referral;**
    l. **Enter the name of the person completing the referral;**
    m. **Enter the referral entities phone number and date of completion;**
    n. **Forward the referral to the appropriate regional office listed on page 2.**
2. **DHEC Care Coordinator:**
    a. **Will enter referral disposition and any relevant notes in the section titled referral disposition;**
    b. **Return form to the person submitting the request.**

OFFICE MECHANICS AND FILING

This form should be filed in the comprehensive health record according to the Health Record Format located in the Health Record Policy Manual. The comprehensive health record retention schedule applies.