REQUEST FOR SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SPECIAL HEALTH SERVICES UNIT
SFN 1103 (8-2023)

Concerns regarding the application process or authorized services should be sent in writing to Special Health Services Unit, Department of Health and Human Services, 600 E Boulevard Ave Dept 325, Bismarck, ND 58505-0200. Questions can be directed to SHS at 800.755.2714.

INSTRUCTIONS: Complete form in its entirety.

SECTION I. CLIENT INFORMATION

Name of Client	Social Security Number	Birth Date

Race (check one box)
☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other/Unknown

Ethnicity (check one box)	Sex
☐ Non-Hispanic ☐ Hispanic ☐ Hispanic Origin Unknown	☐ Male ☐ Female

Is child receiving Supplemental Security Income (SSI)? ☐ Yes ☐ No

Child's Grade in School	Specify the Services Your Child Currently Has
	☐ Individualized Education Program (IEP) ☐ 504 Plan ☐ Individualized Health Plan (IHP)

Name of Parent(s)

Address (Box Number, Street)	City	State	ZIP Code	County

Home Telephone Number	Work Telephone Number	Cell Phone Number

Email Address

HEALTH CARE COVERAGE

Health Care Coverage (check all that apply)
☐ Medicaid ☐ Other Private/Public Insurance ☐ No Source ☐ Healthy Steps/CHIP ☐ Indian Health Service (IHS)

Primary Insurance Company	Policy Date (Month/Day/Year)	Policy Number
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* Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification; failure to disclose this information will not affect the disclosure of information. The Department will not condition treatment on your agreement to authorize disclosure of your health information. The Department may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department health plan.

TURN OVER AND COMPLETE OTHER SIDE

SECTION II. FINANCIAL COVERAGE APPLICATION

Assistance Requested for the Following Medical Condition(s)
Services ☐ Diagnostic Services ☐ Treatment Services ☐ Both

I understand that Special Health Services (SHS) does not cover sums for which there is any type of insurance coverage; or for which there is a recovery of money relative to the physical or medical condition for which application is made and that SHS is to be reimbursed for any payment for which recovery of funds is secured. I agree that the payment of any sums by SHS for services which are covered by insurance or may be recoverable because of the legal liability of a third party, will result in an automatic assignment to SHS of any claim for such sums and I hereby agree to such an assignment. I have read this application or had it read to me, and certify that all statements herein are true to the best of my knowledge.

Signature of Applicant	Date	Relationship	County
Signature of SHS Claims/Eligibility Administrator			Date

Disposition of Application (To Be Completed by State Office Only)

☐ Approved ☐ Not Approved Because:	Effective Date
Signature of Medical Director/SHS Designee	Date