

# PARTICIPANT'S MANUAL



## Children's Special Health Care Services



AUGUST 2018

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## **Children's Special Health Care Services Program**

### **Mission Statement**

The mission of the Children's Special Health Care Services (CSHCS) program is to provide financial assistance for medically necessary treatment of children and youth with special health care needs (CYSHCN), and care coordination to facilitate and promote family-centered, community based, comprehensive, coordinated care that promotes successful systems of care for the CYSHCN and their families in Indiana.

### **Vision Statement**

To promote the health and well-being of CYSHCN

The statutory authority for the CSHCS program can be found in Indiana Code (IC) 16-35-2 and Indiana Administrative Code (IAC) 410 3.2.

See: <http://www.in.gov/legislative/iac/T04100/A00032.PDF?&iacv=iac2016>

## **Terms and Definitions**

### **Basic Dental Care**

Basic dental care consists of examinations, prophylaxis (cleanings) and fluoride treatments every six (6) months, sealants, x-rays, fillings and crowns. The dentist or provider must be enrolled as a CSHCS provider.

### **Basic Primary Care**

Basic primary care consists of examinations, immunizations, sick and well-child visits. The physician or provider must be enrolled as a CSHCS provider.

### **Care Coordination**

Care coordination is a process that links children with special health care needs and their families to services and resources in a coordinated effort to maximize the potential of the children and provide them with optimal health care.

### **Eligible Medical Condition**

The diagnosis for which the participant was approved for the CSHCS program. This diagnosis must fall within the 23 categories of eligible conditions (see appendix A).

### **Exclusions**

Those items or services not covered by the CSHCS program.

### **Explanation of Benefits (EOB)**

A form issued by an insurance company showing that a claim is paid or denied. If the participant has any medical insurance, this form is needed by the provider for every service to be billed to CSHCS. The EOB must be submitted by a provider with a claim to CSHCS and is required for every claim before CSHCS will process the claim for payment.

### **Key Number**

The six-digit computer-generated CSHCS participant identification number.

### **Linked Provider**

The primary care, specialty care or basic dental care provider from whom the participant receives care. Linkages must be established by the CSHCS Medical Eligibility/PA Section before claims can be paid by CSHCS.

### **Medical Home**

A medical home is a respectful partnership between a child, the child's family, and the child's primary health care setting. The medical home is family-centered health care that is accessible, continuous, comprehensive, coordinated, compassionate and culturally competent.

**Out-of-State Care**

Treatment received outside of the State of Indiana. All out-of-state care must have a prior authorization. Emergency room visits must be related to the eligible medical condition and must be reported to CSHCS within five (5) days of the visit.

The following contiguous areas are available for in-state service with an authorized linkage or prior authorization (PA): Louisville, KY; Cincinnati, OH; Harrison, OH; Hamilton, OH; Oxford, OH; Sturgis, MI; Watseka, IL; Danville, IL; and Owensboro, KY.

**Payer of Last Resort**

The CSHCS program is the payer of last resort for authorized services. All other insurance must be billed first for services rendered and an EOB submitted to CSHCS.

**Participant**

The individual receiving services from the CSHCS program.

**Primary Care Provider (PCP)**

A primary care provider may be an individual doctor or clinic that sees the participant for regular visits (e.g., well child physicals) and immunizations. The PCP would also see the participant to treat minor illnesses (colds, flu, etc.). The CSHCS program pays for all office visits, lab work, X-rays or any prescription medications prescribed by the primary care provider.

**Primary Dental Provider (PDP)**

May be an individual dentist or clinic that sees the participant for the basic preventive dental care to keep teeth healthy. Some services covered for routine dental care include: examinations, prophylaxis (cleanings) and fluoride treatments every six (6) months, sealants, X-rays, fillings and some crowns.

**Prior Authorization (PA)**

An authorization statement issued by CSHCS for services related to the eligible medical condition not provided by a linked provider. CSHCS will pay the provider after insurance has been billed. Payment for authorized services will be made only if all CSHCS policy requirements are met.

**Specialized Dental Care**

Specialized dental services needed to treat an eligible medical diagnosis such as cleft lip and palate. A PA is required before specialized dental work begins.

**Specialized Medical Care**

Specialized medical services needed to treat an eligible medical condition(s) (see Appendix A). A PA is required before specialized care begins.

**Specialty Care Provider**

A specialty care provider may be an individual doctor or clinic that sees the participant for treatment of his/her eligible medical condition(s). Sometimes the primary care doctors can also serve as the specialty care doctor. The CSHCS program pays for office visits, lab work, X-rays or any prescription medications prescribed by the specialty care provider. Some specialty services may require a PA (i.e., therapy, durable medical equipment, surgeries, etc).

**Transportation Provider**

A company or individual who transports an enrolled participant to and from authorized medical appointments. Family members may register with CSHCS as Travel Submitters (see Travel and Transportation, page 10).

**Transition**

The movement from one situation to another (e.g., hospital to home, home to school, school to college, college to living alone and from pediatric to adult medical care).

**Important Information**

The CSHCS program is the payer of last resort for authorized services. This means that your primary insurance or Hoosier Healthwise/Medicaid must always process the claim before billing the CSHCS program.

Before receiving your first service under the CSHCS program, call the **Medical Eligibility/PA section at (317) 233-1351 or (800) 475-1355 (Option #3)** to have your child linked to their primary and specialty care providers. You should also review your medical insurance or Medicaid information with the nurse at that time to insure the information is documented accurately. Your assigned nurse will contact you upon program enrollment to assist you with identifying provider linkages, PAs, or other questions you may have concerning this program.

Before CSHCS can pay any medical bills, your providers must be enrolled as CSHCS providers and all **specialty services must be either linked or prior authorized**. Be sure to report any services that were received while your application was pending.

## Services Provided

The CSHCS program provides “Gap Filling” services for enrolled participants. Please make sure that all your providers are authorized through the **Medical Eligibility/PA Section**. The program may pay for medical services only after other health insurance (private or public— Hoosier Healthwise and Medicaid) has paid or denied coverage. The CSHCS program **will normally** pay for the following:

- **Primary Care Visits:** any sick or well-child visits to a linked primary care physician office or clinic.
- **Specialty Care Visits:** health care visits made to a linked specialty care physician or for care related to the eligible medical diagnosis.
- **Basic Preventive Dental Care Visits:** any visit to a linked dentist or dental health provider for routine/preventive dental care as defined by the program.
- **Specialized Dental Care Services:** dental service needed to treat the eligible medical conditions such as cleft lip or palate.
- **Pharmacy Services:** prescriptions for medications/supplies prescribed by your physician. Over-the-counter medications are not usually covered even if the doctor writes a prescription unless the medication is the prescribed treatment for the participant’s eligible medical condition and has been prior authorized. Be sure to contact the **CSHCS Medical Eligibility/PA Section** to ask if it can be covered.

## Authorized Services

It is your responsibility to confirm that your provider is an enrolled CSHCS provider. This can be confirmed with the CSHCS Medical Eligibility/PA Section. If your preferred provider is not already a CSHCS provider you may ask the **CSHCS Medical Eligibility/PA Section** to contact your preferred provider to see if he/she is willing to enroll in the program. If you choose to obtain services from a provider who declines to become a CSHCS provider or without a linkage or authorization, **you will be responsible for the bills.**

Parents/guardians/family members are required to register with the CSHCS program if they wish to be reimbursed for authorized transportation required for the participant to access medical care.

Every participant on the CSHCS program is linked to a primary care provider, a dentist, and if appropriate to a specialty care provider. The linkage covers care provided in those providers’ offices. The linkage remains in place until either the participant requests a change or leaves the CSHCS program, or the provider withdraws from the program.

Specialty care services (e.g., therapies, equipment, supplies, and emergency room visits) must be related to the participant’s eligible medical condition and recommended by the participant’s PCP. These services must have prior authorization from the program before those services are obtained and before reimbursement is made to the provider(s).

CSHCS will pay the Indiana Medicaid allowed rate for all authorized services. This means that, occasionally, the program may not pay the full amount that your provider bills. However, if CSHCS approves payment for a medical service, the provider must accept the CSHCS payment as final payment-in-full. You should not be billed for any balance. If you receive a bill for an authorized service, please contact the provider and ensure that he/she has billed the CSHCS program. If this does not resolve the issue, please contact **(317) 233-1351 or (800) 475-1355 Option #3**.

**All providers and participants/guardians** who submit claims for payment to the State must agree to be reimbursed by electronic funds transfer. This means that anyone who wishes to be reimbursed for travel by CSHCS must set up a **direct deposit account** (please see the Transportation and Travel Section for more detail).

### **Linkages and Prior Authorizations**

A linkage is a way to establish an authorized relationship between the enrolled participant and the medical professional.

A PA is another way of saying “ask before obtaining services.” A prior authorization must be requested by the medical professional and confirms medical necessity and the relationship of the service to an eligible medical diagnosis. **If you do not ensure that services are authorized, bills for those services may not be paid.** A prior authorization is needed for most of the specialty services the participant requires. Prior authorizations remain in place for a specific time period which is normally no longer than six (6) months.

**If a prior authorization is not obtained before receiving services, the resulting bills will be the responsibility of the participant.** If the participant is referred to another provider, the family/participant must ensure that the new provider has authorization to provide those services. Below is a list of some services that require a PA.

- Inpatient services (hospitalizations)
- Equipment and supplies
- Surgery
- Specialized dental care
- Therapy (occupational, physical, speech, ABA)
- Home health care items
- Primary care received from other than the participant’s primary care provider
- Specialty care received from other than the participant’s linked specialty care provider



- Basic dental care received from other than the participant's primary dental provider
- **Emergency room services** - the participant **must notify** the CSHCS program of **emergency care** and unscheduled hospitalizations within five (5) working days of the visit, not including Saturdays, Sundays or legal holidays. An authorization for payment may be written only after the Medical Eligibility/Prior Authorization Section receives the discharge summary or medical notes from the emergency room visit. The **participant is responsible** for seeing that these documents are mailed or faxed to CSHCS. Only services related to the eligible medical condition(s) will be authorized for payment (contact information in Appendix E).
- Medications with a cost greater than or equal to 1,000.

**If you are in doubt about whether or not a service is covered, call the CSHCS Medical Eligibility/PA Section at (317) 233-1351 or (800) 475-1355 (Option #3).**

### **Exclusions (Services Not Covered)**

There are some services, supplies, equipment and medications that CSHCS do not cover. These exclusions are listed below. **This list is not all inclusive. You may confirm that a specific item or service is covered, by calling (317) 233-1351 or (800) 475-1355 Option #3.**

- Over-the-counter drugs (e.g., Tylenol, cough syrup, vitamins, etc.) even with a doctor's prescription
- Over-the-counter supplies (e.g., diapers, non-sterile gloves, alcohol, tape, bleach, band-aids, egg crate mattress covers, etc.)
- Therapy: physical, speech, behavioral, occupational, or Applied Behavior Analysis (ABA) (except as related to eligible medical condition and with a prior authorization)
- Mental health services, counseling, testing and substance abuse treatment
- Emergency room visits for reasons not related to the participant's eligible diagnosis (e.g., if the eligible diagnosis is asthma, the CSHCS program will not cover an emergency room visit for a broken arm)
- Hospitalization for reasons not related to the eligible diagnosis
- Organ transplant surgery
- Eyeglasses, if not related to the eligible diagnosis
- Items provided by a participant's Individual Education Plan (IEP)

## Care Coordination Services

The CSHCS program offers care coordination services to participants and their families. By definition:

Navigating the systems of care can be very challenging for families who have children with special health care needs. One of the goals of care coordination is to provide system navigation support to ensure that treatment interventions, educational, and financial resources are fully identified and maximized. The CSHCS care coordinators are knowledgeable about programs, services, and financial resources that are available to children with special needs. These resources include, but are not limited to, health care financing, educational concerns, Medicaid waiver programs, support groups, and information on the many transitions in life such as transition from the pediatric health care system to the adult health care system. Care coordinators will be contacting all new application and reevaluation approvals of the participant/family and attempt to link families with appropriate community resources, providers, and agencies to assist them.

**To speak with a CSHCS Care Coordinator call (317) 233-1351 or (800) 475-1355 (Option #6).**

## Insurance

For the CSHCS program to consider payment for a specific service, you must follow the rules for your primary insurance coverage. To utilize CSHCS benefits, the participant must:

1. Learn about the benefits of your primary insurance company. CSHCS will not pay for a service that the insurance company has denied because the participant did not follow the rules. For example, claims that are denied by your insurance company because the service was provided out of network will also be denied by CSHCS. Payment for these services may be the responsibility of the participant.
2. Upon receipt of this packet, call the **CSHCS Medical Eligibility/PA Section (317) 233-1351 or (800) 475-1355 (Option #3)** regarding your primary insurance/Medicaid to ensure that the information is documented accurately. Report all changes regarding your insurance coverage to providers and the CSHCS program as soon as they occur. Failure to disclose insurance benefits may result in individual claims being denied or the participant being removed from the CSHCS program.
3. Inform your providers to bill all other medical insurance first. This includes Hoosier Healthwise, Medicaid, and Medicare in addition to private insurance. CSHCS should then be billed with an EOB (explanation of benefits) attached to the claim.
4. If your other insurance requires a PA for a service, it is the responsibility of the participant to get that PA before the service is rendered. If the insurance denies a service because the participant did not get prior authorization, CSHCS will also deny the claim and the bill will remain the responsibility of the participant.
5. **CSHCS may ask you to appeal denials by your insurance company.** It may be that the insurance company requires more information. Please cooperate with any request made by your insurance company for further information. CSHCS will not approve any claim that is still pending with your insurance company or a claim that was denied by your insurance company due to incomplete information.
6. CSHCS will cover all or part of the participant's deductible and/or co-payments (up to the total reimbursement limit) for each instance of a service authorized by CSHCS.

Remember, it is important to seek services from CSHCS providers. These providers should not bill you for authorized services rendered. **CSHCS will only pay the providers** and will not reimburse the participant for deductibles, co-payments or balances that the participant pays. **It is the responsibility of the participant to inform providers that bills must be sent to CSHCS within one (1) year of the date of the service.** The participant may be responsible for any unpaid bill.

### **Participant's Responsibility**

**You must notify the CSHCS Financial Eligibility Section if any of the following occur:**

- Address or name changes
- Change of phone number
- Changes of household income or occupants
- Changes to an enrolled participant's marital status
- An enrolled participant's legal emancipation
- Changes in insurance coverage (change of company, Hoosier Healthwise/Medicaid, service coverage or termination)
- Change of guardianship
- Parent/guardian name change (e.g., as a result of marriage or divorce)
- The death of a participant

**You must notify the CSHCS Medical Eligibility/PA Section if any of the following occur:**

- A participant's enrollment in a residential institution
- Requested changes of providers
- Emergency room visits five (5) days of the visit
- Hospital admission within five (5) days of the admission and discharge
- You must always confirm with your provider that an authorization for services has been received.
- You must inform your provider of your primary and secondary insurance, Medicaid, and any changes or billing issues before services are rendered.

## **What to Do if You Receive a Bill**

If you receive a bill, never assume that the provider sent you the bill by mistake. Contact the provider immediately to see why you received the bill. Make sure that the provider knows to bill your insurance company or Hoosier Healthwise/Medicaid coverage first, and then the CSHCS program. Be sure the provider has the correct mailing address for CSHCS:

Indiana State Department of Health  
CSHCS – Section 5C  
2 North Meridian Street  
Indianapolis, IN 46204

**If the provider says that the participant is responsible for the balance of a bill paid by CSHCS, contact the Claims & Provider Relations Section at (317) 233-1351 or (800) 475-1355 (Option #5) immediately.** CSHCS may not be able to help you if the bill has gone to a collection agency. Services that have been denied as a non-covered service by the CSHCS program are the participant's responsibility. There are also some services that CSHCS will not cover. Those exclusions are listed on page 7.

## **Transportation and Travel Reimbursement**

Effective July 1, 2010, the CSHCS program has discontinued travel reimbursement for participants dually enrolled in both CSHCS and Medicaid/Hoosier Healthwise (HHW). Dually enrolled participants will need to contact their Medicaid/HHW assigned health plan to arrange transportation.

The cost of traveling to and from a network provider for approved services may be reimbursed to the parent, foster parent or legal guardian of a participant if the following conditions are met.

1. Reimbursement (money paid back to you) will be made at 50 percent of the rate established by the Department of Administration and approved by the Agency.
2. Effective July 1, 2009, the first 49 miles one-way or round trip will not be reimbursed. Only mileage that exceeds 49 miles one-way or round trip will be reimbursed.
3. Mileage will not be approved for trips in excess of 2,500 miles round trip.
4. All mileage is based on the city-to-city calculation from the Indiana State Mileage Chart and **not the odometer reading from your vehicle.**
5. All signatures submitted on the Travel Voucher must be original.
6. All sections of the Travel Voucher must be completed legibly.
7. A maximum of three (3) travel dates may be submitted per one Travel Voucher.
8. Anyone requesting Travel Reimbursement must have filed (one time only) completed W-9 and Direct Deposit forms (See Appendix D).

9. The CSHCS program will not reimburse for transportation to visit a hospitalized participant, parking, meals or lodging.

State law now requires any person and/or entity who submits claims for payment by the State to be reimbursed by electronic funds transfer. This means that if you wish to be reimbursed for family travel by the CSHCS program, you must submit information to set up direct deposit. **Information on the direct deposit process and forms required are located in Appendix D.**

Vouchers must be submitted within one (1) year of the date of travel. For example, if you traveled to the doctor on May 1 of 2013, we must have received your travel vouchers in our office prior to May 1, 2014. **Blank travel vouchers and the W-9 and Direct Deposit forms can be obtained from our website or by contacting us directly at (317) 233-1351 or (800) 475-1355 (Option #4).**

Properly signed and completed travel vouchers must be mailed to the CSHCS office:

Indiana State Department of Health  
CSHCS – Section 5C  
2 North Meridian Street  
Indianapolis, IN 46204

## **Re-Evaluations**

Once a year from the date of initial application, participants are re-evaluated to determine if there have been changes in their eligibility status. The re-evaluation is required to maintain active status on the program. CSHCS will notify you by mail when you are required to submit information for your annual re-evaluation.

During the re-evaluation you will be asked to provide information on all household members' income (related and not related) including, earned and unearned income. Preferred documentation includes the most **recent three (3) consecutive paycheck stubs** for all household members. If you are self-employed and/or have other income that is not reflected on your paycheck stubs, you must provide a copy of all household members' latest **federal tax form 1040** or other documents that can verify income. If household members do not file federal taxes, submit written documentation of all household income received (i.e., last three consecutive check stubs and a statement declaring that no other income is received). **Additional documentation may be requested.**

If income has drastically changed from the time taxes were filed, (e.g., change in job, hours or pay, no longer working) submit the latest **federal tax form 1040** along with written documentation of current income (i.e., the last three consecutive check stubs or a written statement from your employer on the company's letterhead) indicating salary or indicating last day employed. **Additional documentation may be requested.** Remember, although there will be an annual reevaluation, the parent/guardian/participant is still responsible for informing the CSHCS program of any changes in financial information that occur during the year.

When you receive notification of the re-evaluation, you must return the information requested by the due date in the letter. Failure to return the updated information could result in the participant being removed from the CSHCS program. If you have any questions, please call the **CSHCS Financial Eligibility Section at (317) 233-1351 or (800) 475-1355 (Option #2).**

## **Case Closures: Removal from the CSHCS Program**

The participant may be removed from the CSHCS program for various reasons. Some of the reasons the participant's enrollment may be terminated:

- Failure to complete and return the annual re-evaluation packet within the required time
- Failure to provide updated income information
- Failure to utilize health insurance benefits and/or provide updated health insurance Information
- Failure to provide current address information
- Failure to apply for Medicaid/Hoosier Healthwise
- Loss of state residency – participant is no longer an Indiana resident (moves out of state)
- Death of participant
- The participant has turned 21 years of age. Participants with Cystic Fibrosis are not subject to the age limitation, but must remain financially eligible

## **Transition**

Transition is the movement from one situation to another (e.g., hospital to home, home to school, school to college, pediatric care to adult medical care, and/or from family living to living independently as an adult). It is important to know the tools and resources available to transition youth with special health care needs. Some of the systems that families understand well in the pediatric world have different rules in adult life. For example, individuals with disabilities may or may not meet eligibility for Supplemental Security Income (SSI) benefits when they turn 18. Prior to age 18, family income is considered in financial eligibility for SSI. After 18, only the individual's income is considered.

When your child reaches adulthood, he or she will transition out of the range of school services guaranteed under the Individuals with Disabilities Education Act (IDEA). Beginning at age 14, a transition plan should be developed and updated annually for those children with an Individual Educational Program (IEP).

Youth must be ready to speak for themselves as they turn 18. Regardless of the level of disability, an individual automatically becomes his or her own legal guardian or decision-maker upon turning 18 unless legal guardianship is pursued. While most young adults with special health care needs continue to look for recommendations and support from their families, once 18, the person is able to sign legal documents and contracts. The person becomes responsible for medical care such as making own appointments, getting medicines, and requesting equipment.

Transition is the natural progression through life. There are many transitions that occur in the life of any child. Each change has some potential to be scary and bring up many questions. In busy lives, it is sometimes difficult to stop and plan for the future. However, planning today for tomorrow's goals is very important to actually achieving those goals.

The CSHCS program has identified some state and national websites for your information. The websites listed below include health care, educational, employment and recreational information. It is our hope that these sites will help in all phases of transitioning from childhood to adulthood.

## State and National Transition Resources

### **Center for Youth and Adults with Conditions of Childhood (CYACC):**

**<http://iuhealth.org/riley/community-pediatrics/transition-clinic/the-cyacc-team/>**

Provides consultation for youth and adults preparing to transition from pediatric to adult health care as well as all related issues for a successful transition to adulthood. Phone: (866) 551-0093.

**Disability.gov: [www.disability.gov](http://www.disability.gov)** - This federal website links to information of interest to people with disabilities and their families. Topics include employment, education, housing, transportation, health, income support, technology, community life, and civil rights.

**Benefits.gov: [www.benefits.gov](http://www.benefits.gov)** - A partnership of federal agencies and organizations with enhance access to government assistance programs. There is a confidential online screening tool that can help individuals find out which federal government programs and benefits they may be eligible to receive. Toll-Free Phone: (800) 333-4636.

**Got Transition: [gottransition.org](http://gottransition.org)** - This site contains transition-related information, tools, resources and links to many transition-related websites. Phone: (202) 223-1500.

**National Center on Secondary Education & Transition: [ncset.org](http://ncset.org)** - Includes resources related to education, training, independent living and work for youth with disabilities.

**Social Security: [ssa.gov/disability](http://ssa.gov/disability)** - Site contains information about eligibility and applications for SSI and SSDI. Toll-Free Phone: (800) 772-1213 or (800) 325-0778 (TTY).

**The Arc of Indiana: [www.arcind.org](http://www.arcind.org)** - This site provides valuable information concerning transition and other services, including guardianship information. Toll-Free Phone: (800) 382- 9100.

**Medicaid/Hoosier Healthwise: [www.in.gov/fssa](http://www.in.gov/fssa)** - A public health insurance for children to age 19 and those with disabilities. Toll-Free Phone: (800) 889-9949.

**MCM-MOMS Helpline: <http://www.MomsHelpLine.isdh.in.gov>** - A statewide health information and referral service. Toll- Free Phone: (844) 6246667 or (855) MCM-MOM.

**Mental Health America of Indiana: [mentalhealthassociation.com](http://mentalhealthassociation.com)** - Resource for services to address mental health needs. Toll-Free Phone: (800) 555-6424.



**Indiana Institute on Disability & Community:** [iidx.indiana.edu](http://iidx.indiana.edu) - This center on transition provides resources and technical assistance to families and professionals. Toll-Free Phone: (800) 433-0746.

**Division of Aging and Rehabilitative Services:** [www.in.gov/fssa/2328.htm](http://www.in.gov/fssa/2328.htm) - Provides services for Developmental Disability, Vocational Rehabilitation, Visual and Hearing Impaired and Aging and In-Home Services. Toll-Free Phone: (800) 545-7763.

**Indiana Council on Independent Living (ICOIL):** [icoil.org](http://icoil.org) - Provides information and peer support to individuals with disabilities regarding independent living services. Toll-Free Phone: (317) 232-7770.

**Indiana Governor's Planning Council:** [www.in.gov/gpepd](http://www.in.gov/gpepd) - Advances independence, productivity, and inclusion of people with disabilities in all aspects of society. Phone: (317) 232-7770

**Special Education:** [www.doe.in.gov/exceptional/speced/welcome.html](http://www.doe.in.gov/exceptional/speced/welcome.html) - Special education programs for eligible children who qualify from the ages of 3 through 21. Toll-Free Phone: (877) 851-4106.

**Indiana Protection and Advocacy Services:** [www.in.gov/ipas/](http://www.in.gov/ipas/) - Provides information and support about the rights of children and adults with disabilities. Toll-Free Phone: (800) 622-4845.

**About Special Kids (ASK):** [www.aboutspecialkids.org](http://www.aboutspecialkids.org) - Provides information, peer support to families of youth and young adults with special needs. Toll-Free Phone: (800) 964-4746.

**IN\*SOURCE:** [insource.org](http://insource.org) - Provides information, peer support to families of youth and young adults with special needs. Toll-Free Phone: (800) 332-4433.

**Family Voices Indiana:** [fvindiana.org](http://fvindiana.org) - Provides information, training and one-on-one support of children and youth with special needs. Toll-Free Phone (844) 323-4636.

## Appendices

### A. List of Eligible Medical Conditions

There are multiple diagnoses associated with the conditions listed below. Please contact the Medical Eligibility/PA Unit for clarifications at (317) 233-1351 or (800) 475-1355 (Option #3).

- Apnea
- Arthritis
- Asthma – severe, two medications daily
- Autism
- Cerebral Palsy
- Chronic Anemia (e.g., Sickle Cell)
- Chromosomal Disorders
- Chronic Pulmonary Disease
- Cleft Lip and/or Palate
- Congenital or Acquired Developmental Deformities
- Congenital Heart Disease or Arrhythmias
- Cystic Fibrosis
- Endocrine Deficiencies (e.g., Diabetes)
- Hydrocephalus
- Inflammatory bowel Disease
- Inborn Errors of Metabolism (e.g., PKU)
- Myelodysplasia or Spinal Cord Dysfunction (e.g., Spina Bifida)
- Neuromuscular Dysfunction (e.g., Cerebral Palsy)
- Oncologic Disorders (e.g., Cancer)
- Bilateral Hearing Loss – (at 40 decibels or above)
- Renal Disease
- Seizure Disorder
- Severe Hemophilia

## B. Summary of Important Information

1. The CSHCS program pays for all authorized care as well as specialty care related to the participant's eligible medical condition. It is your responsibility to confirm that your provider has received authorization for services provided.
2. You **must** contact the CSHCS Medical Eligibility/PA Section (317) 233- 1351 or (800) 475-1355 (Option #3) or the TTY Number (866) 275-1274 upon receiving your approval letter for enrollment in order to link the participant with services. **Payment for services will not be processed until this is done.** Be sure to talk to the Medical Eligibility/Prior Authorization Unit nurse about any services received since your application was submitted to see if they are covered.
3. The program may pay for emergency care received outside the primary care physician's office only if the treatment is related to the participant's eligible diagnosis. You **must** call the CSHCS program at the (317) 233-1351 or (800) 475-1355 (Option #3) or the TTY number within five (5) working days of receiving such emergency care.
4. Payment may be made for certain equipment related to the participant's eligible condition with a prior authorization. Contact the PA Section for specific guidance.
5. Please contact CSHCS Medical Eligibility/PA Section (317) 233-1351 or (800) 475-1355 (Option #3) with any changes to your current medical condition or any additional complications that have been documented by your physician.
6. If you have other health insurance for your child, you are required to provide that information to the CSHCS program. Your insurance provider will be the primary payer. **This means that your insurance company must be billed first for any services rendered.** You may need to submit a claim to your insurance provider yourself for some medical care, equipment or prescription drugs. If you belong to a HMO, PPO, or if your care is managed through Medicaid, you must follow their guidelines for coverage.
7. You must send any money you receive directly from your insurance company to CSHCS as reimbursement of money paid to the providers for services provided for the CSHCS participant. Failure to do so will result in your case being closed and coverage terminated.
8. **All providers and participants/guardians** who submit claims for payment to the State must agree to be reimbursed by electronic funds transfer. This means that anyone who wishes to be reimbursed for travel by CSHCS must set up a **direct deposit account.**

## C. Notice of Privacy Practices

*Para Recibir Este Documento En Espanol Por Favor Contactar Al Indiana Family Helpline (Linea De Ayuda Para Las Familias De Indiana) Al (855) 435-7178.*

### INDIANA STATE DEPARTMENT OF HEALTH CHILDREN WITH SPECIAL HEALTH CARE SERVICES

#### Effective June 1, 2013

#### Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.** This notice explains your rights to control your health information. Your health information will not be shared without your written authorization except as described in this notice, or when required or permitted by law. We reserve the right to revise our privacy practices and make new privacy provisions for medical information we maintain. Should changes to the terms of this notice be made, an updated notice will be made available to you.

#### ***YOU NEED NOT DO ANYTHING AS A RESULT OF THIS NOTICE***

#### Our Responsibilities and Commitment to You

We understand that your health care information is personal. We take our responsibility to keep your personal health information private very seriously. We are committed to following all state and federal laws that protect your health information. We are required by law to do the following:

- i Protect your health information.
- i Give you this notice to explain our responsibilities and the ways we use and share your health information.
- i Abide by the terms of this notice.
- i Notify you following a breach of your unsecured protected health information.

#### Your Rights

You have the following rights:

- i You have the right to request a paper copy of this notice at any time, even if you agree to receive it electronically (by e-mail).
- i You have the right to see and get a copy of your personal health information. You will be charged a copy fee per page. You may request an electronic copy of your personal health information; however, we may charge a fee for the creation of such a copy. The fee shall not be greater than the labor cost associated with a paper copy. We may deny your request to see and get a copy of your health information under limited circumstances. If you feel access to your medical information has been wrongly denied you may file an appeal with the Privacy Officer. If an appeal is filed with the Privacy Officer, an individual who did not participate in the decision to deny will review the appeal.
- i You have the right to ask that we change health information that you feel is incorrect or incomplete. Your request may be denied if the information was not created by us, is not part of the information you are allowed to review or copy, or if we decide the personal health information is accurate and complete.
- i You have the right to request a list showing each time we released your personal health information. This list will not include personal health information that was released to provide treatment to you, to obtain payment for services, or for

administrative or operational purposes. This list will not include information released to you that you requested in writing, information released to others with your written approval, information released to persons who are involved in your care, or information released before April 14, 2003.

- ï You have the right to request that we not release your personal health information, release only part of your information, or release it for reasons you request. We may not be legally required to honor your request. However, we are obligated to honor your request if:
  - a) The disclosure is to a health plan for payment or health care operations, but not for the purpose of treatment; and
  - b) The protected health information pertains solely to a health care item or service for which you paid the healthcare provider in full out of pocket.
- ï You have the right to request that we contact you about your personal health matters in a certain way or at a certain location. For example, you can request that we only contact you at work or by e-mail. We will review and accommodate reasonable requests. To request a special way or location for us to contact you about your personal health information, you must call or write to the Privacy Office at the phone number or address in the contact information at the end of this notice.

**Use and Disclosure  
of Your Health  
Information**

We do not create health records. We receive health information to determine eligibility for this program. Information is also received as a claim for payment from the health care practitioners who provide services to you. We may use your health information to pay for services provided to you by your health care provider, for administrative and operational purposes, and to evaluate the quality of services you receive. Uses of your medical information not mentioned in this Notice will not be made without your written authorization. If you sign an authorization it may be revoked by giving written notice of the revocation. While we cannot describe all cases related to the legal use of your health information, the following are some common examples of how we use your personal health information:

- ï We may use your health information to determine if treatment is medically necessary or that you are provided proper treatment.
- ï Physicians, hospitals, and other health care practitioners that provide services to you submit health information to us in the form of a claim for payment. This payment request includes information that identifies you, the diagnosis, and procedures. We use this health information to pay for the services, in accordance with program rules and regulations. We may also share your information with other programs, such as Medicaid, or private insurance companies to coordinate benefits and payments.
- ï Members of our staff may use your health information to review the care and outcome of your treatment and to compare the outcomes of other recipients who received the same or similar treatment.
- ï We may disclose your health information to the workforce involved in the administration of this program. We may also disclose your health information to contractors so they can perform the jobs we ask them to do, such as authorizing services for you or reviewing payments made to health care practitioners. To protect your health information we require contractors to follow rules to protect your information.
- ï We may use and disclose your health information to provide appointment reminders, tell you about possible treatment options, alternative treatments, and for other health-related benefits.
- ï We may disclose or share your health information with other government agencies that may provide public benefits or services to you, such as, First Steps.

- i We may use or disclose your health information in compliance with the law and as required by law in response to a court order. If your health information involves a communicable disease, that information, with limited exceptions, will not be disclosed without your written authorization.

**Filing a Complaint**

If you believe that we have violated your rights or our health information practices, you may file a complaint with our Privacy Officer. You can contact us regarding a complaint by using the following address or phone number. You also can file a complaint with the Indiana Attorney General’s Office, as well as the federal Office of Civil Rights (OCR) in the U.S. Department of Health and Human Services. If the alleged violation took place in Indiana, use the OCR Region V address or telephone number below:

Privacy Officer Office of Legal Affairs Indiana State Dept. of Health 2 N. Meridian St. Indianapolis, IN 46204 317-233-7655	Indiana Attorney General Consumer Protection Division 302 W. Washington St., 5 <sup>th</sup> Floor Indianapolis, IN 46204 317-232-6330 800-382-5516	US Dept. Health & Human Services Office for Civil Rights – Region V 233 N. Michigan Ave. – Suite 240 Chicago, IL 60601 312-866-2359
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**We will never retaliate against you for filing a complaint and it will in no way impact the health care services provided to you.**

#### **D. Travel Reimbursement Documents**

There are two documents that a parent, guardian or participant must complete before travel reimbursement can occur and this process may take several weeks to complete. The forms that need to be completed and submitted are a Vendor Information Form and a Family Travel Voucher. These forms are included in this Appendix.

These forms may also be obtained by going to the following Federal and State of Indiana websites and printing them off or by calling the CSHCS office, (317) 233-1351 or (800) 475-1355 (Option #4), and asking to have them mailed to you.

W-9	<a href="http://www.irs.gov/pub/irs-pdf/fw9.pdf">http://www.irs.gov/pub/irs-pdf/fw9.pdf</a>
Direct Deposit Form	<a href="https://forms.in.gov/Download.aspx?id=11695">https://forms.in.gov/Download.aspx?id=11695</a> Reimbursement
for Travel	<a href="https://forms.in.gov/Download.aspx?id=5781">https://forms.in.gov/Download.aspx?id=5781</a>

Whenever there is a change in address or banking information, the parent, guardian or participant is required to complete and submit a new W-9 and/or Direct Deposit form. Failure to do this will result in a delay of reimbursement payments.

#### **E. Contact Information**

Indiana State Department of Health CSHCS –  
Section 5C  
2 North Meridian Street Indianapolis IN  
46204  
Phone: (317) 233-1351 or (800) 475-1355  
Fax: (317) 233-1342  
<http://cshcs.isdh.in.gov/>

#### **F. Phone Menu Options:**

- |  |   |
|--|---|
| 1. Translation en Español                      | Options de translation para todos los programas                                 |
| 2. Eligibility                                 | Eligibility criteria status of pending applications and re-evaluation questions |
| 3. Medical Eligibility/<br>Prior Authorization | Linkages and PA service requests  |
| 4. Family Travel                               | Questions regarding family travel reimbursement                                 |
| 5. Claims & Provider Relations                 | Billing questions, procedures, and provider enrollment                          |
| 6. Care Coordination                           | Resources and referrals   |





# Request for Taxpayer Identification Number and Certification

**Give Form to the  
requester. Do not  
send to the IRS.**

▶ Go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9) for instructions and the latest information.

See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
2 Business name/disregarded entity name, if different from above	
3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.  <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate  <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____ <b>Note:</b> Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.  <input type="checkbox"/> Other (see instructions) ▶ _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):  Exempt payee code (if any) _____  Exemption from FATCA reporting code (if any) _____  <small>(Applies to accounts maintained outside the U.S.)</small>
5 Address (number, street, and apt. or suite no.) See instructions.	Requester's name and address (optional)
6 City, state, and ZIP code	
7 List account number(s) here (optional)	

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

**Note:** If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

<b>Social security number</b>  _ _ _ - _ _ - _ _ _ _
<b>or</b>
<b>Employer identification number</b>  _ _ - _ _ _ _ _ _ _

### Part II Certification

Under penalties of perjury, I certify that:

- 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- 3. I am a U.S. citizen or other U.S. person (defined below); and
- 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

<b>Sign Here</b>	Signature of U.S. person ▶ _____	Date ▶ _____
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### General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments.** For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9).

### Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
  - Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
  - Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
  - Form 1099-S (proceeds from real estate transactions)
  - Form 1099-K (merchant card and third party network transactions)
  - Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
  - Form 1099-C (canceled debt)
  - Form 1099-A (acquisition or abandonment of secured property)
- Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting*, later, for further information.

**Note:** If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

## Backup Withholding

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the instructions for Part II for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code*, later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships*, earlier.

## What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code*, later, and the Instructions for the Requester of Form W-9 for more information.

## Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

## Penalties

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

## Specific Instructions

### Line 1

You must enter one of the following on this line; do not leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

**a. Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

**Note: ITIN applicant:** Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

**b. Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

**c. Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

**d. Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

**e. Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

### Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

### Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

### Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

#### Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

- 1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)
- 2—The United States or any of its agencies or instrumentalities
- 3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities
- 4—A foreign government or any of its political subdivisions, agencies, or instrumentalities
- 5—A corporation
- 6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession
- 7—A futures commission merchant registered with the Commodity Futures Trading Commission
- 8—A real estate investment trust
- 9—An entity registered at all times during the tax year under the Investment Company Act of 1940
- 10—A common trust fund operated by a bank under section 584(a)
- 11—A financial institution
- 12—A middleman known in the investment community as a nominee or custodian
- 13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup>	Generally, exempt payees 1 through 5 <sup>2</sup>
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

<sup>1</sup> See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup> However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

**Exemption from FATCA reporting code.** The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

- A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)
- B—The United States or any of its agencies or instrumentalities
- C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities
- D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)
- E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)
- F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state
- G—A real estate investment trust
- H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940
- I—A common trust fund as defined in section 584(a)
- J—A bank as defined in section 581
- K—A broker
- L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

**Note:** You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

**Line 5**

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

**Line 6**

Enter your city, state, and ZIP code.

**Part I. Taxpayer Identification Number (TIN)**

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

**Note:** See *What Name and Number To Give the Requester*, later, for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at [www.SSA.gov](http://www.SSA.gov). You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at [www.irs.gov/Businesses](http://www.irs.gov/Businesses) and clicking on Employer Identification Number (EIN) under Starting a Business. Go to [www.irs.gov/Forms](http://www.irs.gov/Forms) to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to [www.irs.gov/OrderForms](http://www.irs.gov/OrderForms) to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note:** Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

**Part II. Certification**

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code*, earlier.

**Signature requirements.** Complete the certification as indicated in items 1 through 5 below.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

### What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup>
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
5. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee <sup>1</sup> The actual owner <sup>1</sup>
6. Sole proprietorship or disregarded entity owned by an individual	The owner <sup>3</sup>
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*

  

For this type of account:	Give name and EIN of:
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee

For this type of account:	Give name and EIN of:
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

<sup>1</sup> List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

<sup>4</sup> List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships*, earlier.

\*Note: The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

### Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

**Protect yourself from suspicious emails or phishing schemes.** Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to [phishing@irs.gov](mailto:phishing@irs.gov). You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at [spam@uce.gov](mailto:spam@uce.gov) or report them at [www.ftc.gov/complaint](http://www.ftc.gov/complaint). You can contact the FTC at [www.ftc.gov/idtheft](http://www.ftc.gov/idtheft) or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see [www.IdentityTheft.gov](http://www.IdentityTheft.gov) and Pub. 5027.

Visit [www.irs.gov/IdentityTheft](http://www.irs.gov/IdentityTheft) to learn more about identity theft and how to reduce your risk.

### Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.



**AUTOMATED DIRECT DEPOSIT  
AUTHORIZATION AGREEMENT**

State Form 47551 (R7 / 5-18)  
Approved by State Board of Accounts, 2018  
Prescribed by Auditor of State, 2018

\* This agency is requesting disclosure of your Federal Identification Number / Social Security Number in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.

In accordance with **IC 4-13-2-14.8**, a person who has a contract with the State of Indiana or submits invoices to the State of Indiana for payment shall authorize the direct deposit by electronic funds transfer of all payments by the state to the person.

This form must be completed in order to receive payment from the State of Indiana and any time there is a change in banking information. This form must be accompanied by a W9. If you are changing an e-mail address to receive electronic notifications of EFT deposits, please contact [vendors@auditor.in.gov](mailto:vendors@auditor.in.gov).

New Enrollment

Change of Existing Account

Prior Routing Number: \_\_\_\_\_

Prior Account Number: \_\_\_\_\_

**SECTION 1: AUTHORIZATION**

According to Indiana law, your signature below authorizes the transfer of electronic funds under the following terms:

\_\_\_\_\_  
Name of Company or Individual (as shown on the account)

\_\_\_\_\_  
Federal Identification Number / Social Security Number \*

\_\_\_\_\_  
Address (Number and Street and/or PO Box Number)

\_\_\_\_\_  
City, State, and ZIP Code (00000-0000)

**SECTION 2: DIRECT DEPOSIT INFORMATION**

Type of Account:  Checking (Demand)  Savings

Please check this box if your direct deposit will be automatically forwarded to a bank account in another country.

Financial Institution: \_\_\_\_\_

Routing Number (9 digits): \_\_\_\_\_

Account Number (maximum 17 digits – include leading zeros): \_\_\_\_\_

**SECTION 3: E-MAIL ADDRESS TO RECEIVE ELECTRONIC NOTIFICATION OF ELECTRONIC FUND TRANSFER (EFT) DEPOSITS \*Required**

(Please contact [vendors@auditor.in.gov](mailto:vendors@auditor.in.gov) to add more than four addresses.)

All future notices of EFT deposits to the bank account specified above will be sent to the following e-mail addresses:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

By checking this box, I authorize the information provided on this form to be accurate and I agree with the provisions on the reverse side of this form. I also authorize the State of Indiana to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account indicated above. This authorization will remain in effect until the state has received written notification of its termination and has adequate time to act upon the request.

NAME (type) \_\_\_\_\_ TITLE \_\_\_\_\_ TELEPHONE \_\_\_\_\_

AUTHORIZED SIGNATURE\* \_\_\_\_\_ DATE (month, day, year) \_\_\_\_\_

\* Under **IC 26-2-8-106**, your electronic signature on this form represents the same legal authority as your written signature.

**INSTRUCTIONS:**

1. *Complete all three sections and sign and date the bottom of the form.*  
*Note: If signing electronically, the form must be saved first, and then opened in Adobe Acrobat. For help in creating a digital ID please click [here](#).*
2. *File the completed form with the agency that you do business with.*
3. *Retain a copy of the completed form for your records.*

By Signing This Form:

You are responsible for ensuring that this form was approved and instructions above are followed. By signing this form, you represent that it is understood by all parties that, if approved:

1. The State of Indiana must initiate credits (deposits) in various amounts, by electronic transfer of funds through automated clearing house (ACH) processes, to the listed checking (demand) or savings account designated in the financial institution named in Section 2.
2. If necessary, you will accept reversals from the State for any credit entries made in error to the bank account per National Automated Clearing House Association (NACHA) regulations.
3. You may only revoke this request and authorization by notifying the Auditor of State (AOS) by e-mailing [vendors@auditor.in.gov](mailto:vendors@auditor.in.gov) or in writing at the following address: **Indiana Auditor of State, 200 W Washington St. Ste 240, Indianapolis, IN 46204**. The authorization will remain in effect until the office has adequate time to act upon the request.
4. A new Automated Direct Deposit Authorization Agreement is required for change in existing account information. The previous account information must be provided. Failure to timely notify the AOS of an account change will delay payment.
5. The State of Indiana and its entities are not liable for late payment penalties or interest if you fail to provide information necessary for an electronic funds transfer and/or you do not properly follow these Instructions.
6. E-mail address(es) must be provided in Section 3 to allow for appropriate application of all payments through Electronic Notification.
7. You acknowledge that it will cause disruption to the notification process if the e-mail addresses provided for electronic funds transfer notification are frequently changed or changed without promptly providing an updated e-mail address to the AOS.
8. You acknowledge that an e-mail notification returned as undeliverable may be removed from the Auditor's e-mail notification system.
9. You are responsible for contacting the AOS if you are not receiving electronic notices of EFT deposits.





**REIMBURSEMENT FOR TRAVEL  
TO/FROM APPROVED PROVIDER(S) FOR  
50 MILES OR MORE ROUNDTrip**

State Form 50254 (R/12-03)  
Form approved by State Board of Accounts, 2003

**INSTRUCTIONS**

1. All sections completed, printed, and legible.
2. Signatures must be original in ink.
3. Maximum of three (3) travel dates per form.
4. One year filing limit from date of travel.
5. Return to CSHCS.

INDIANA STATE DEPARTMENT OF HEALTH  
CHILDREN'S SPECIAL HEALTH CARE SERVICES  
(CSHCS)  
2 NORTH MERIDIAN STREET  
INDIANAPOLIS, INDIANA 46204

PARTICIPANT INFORMATION		COMPLETED BY PARENT/GUARDIAN
Name of Child	Date of Birth (month, day, year)	CSHCS #
Street address of participant (number and street, city, state, ZIP code (spell city name completely))		

TRANSPORTATION INFORMATION		COMPLETED BY PARENT/GUARDIAN/DRIVER
Date(s) of Travel (month, day, year & maximum of three per claim)		
To (number and street, city, state, ZIP code (spell city name completely))		
Reason(s) for Visit(s)		
Name of Driver	Driver's License # (provide copy if not Indiana)	
Driver's Date of Birth	Vehicle Plate # (provide copy of registration if not Indiana)	

MEDICAL PROVIDER INFORMATION		COMPLETED BY MEDICAL PROVIDER
Name of Medical Provider (printed)		
Signature of Medical Provider (must be in ink)	Date (month, day, year)	

PARENT/GUARDIAN INFORMATION		COMPLETED BY PARENT/GUARDIAN
Mailing address of parent/guardian, if different from above (number and street, city, state, ZIP code (spell city name completely))		
Name of Parent/Guardian (printed)		
Signature of Parent/Guardian (must be in ink)	Date (month, day, year)	
I hereby certify that the foregoing account is just and correct, that the amount claimed is legally due, after allowing all just credits, and that no part of the same has been paid.		







Indiana State  
Department of Health

Children's Special Health Care Services

2 North Meridian Street

Section 5C

Indianapolis IN 46204

(317) 233-1351 or 1 (800) 475-1355

[cshcs.in.gov](http://cshcs.in.gov)