SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

CYSHCN SERVICES REQUEST FORM

Children and Youth with Special Health Care Needs

Name:	**DOB:**
Birth Sex: ☐ Male ☐ Female ☐ Unknown	
Parent/Guardian Name:	
Primary Language:	**Phone #:**
Email Address:	
Street Address:	
City, State, Zip Code:	**County:**
Diagnosis(es):	**ICD Code(s):**

Services Requested:

☐ **Hearing:** Attach documentation of diagnosis and ICD code, including degree and type of hearing loss. Attach most recent audiology report and audiogram or ABR with tracing. Attach Medical Clearance statement if requesting Hearing Aids, Cochlear Implants, or Bone Anchored Hearing Aids.

☐ **Orthodontia:** Attach Orthodontic Program Plan of Care (0911-ENG-DPH), documentation of craniofacial anomaly, and pictures. Indicate Limited or Comprehensive requested below:

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

☐ **Special Formula:** Attach documentation of diagnosis and ICD code, clinical notes to include anthropometrics, and formula prescription(s) (4006-ENG-DPH).

☐ **CRS (Children's Rehabilitative Services):** Attach documentation of diagnosis and ICD code, prescription(s), and most recent clinical note.

☐ **Adult Sickle Cell:** Attach documentation of diagnosis and ICD code.

☐ **Hemophilia:** Attach documentation of diagnosis and ICD code.

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

Insurance(s):

☐ **Medicaid** ▶ **Plan:** _____ **#:** _____

☐ **Private** ▶ **Plan:** _____ **#:** _____

☐ **None**

Agency or Practice Making Referral:	
Name of Person Referring:	
Phone #:	**Date:**

Send completed form via Mail, Fax, or Secured Email to the CYSHCN Regional Office covering the client's county of residence.

(see reverse for contact information)

CYSHCN Regional Offices

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

Greenville County Health Department
352 Halton Road, Greenville, SC 29607

Phone # (864) 372-3065 **or** (864) 372-3063
Fax # (864) 282-4394

Email upstatecyshcnrequests@dph.sc.gov

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

Richland County Health Department
2000 Hampton Street, Columbia, SC 29204

Phone # (803) 576-2800
Fax # (803) 576-2820

Email midlandscyshcnrequests@dph.sc.gov

Pee Dee Region CYSHCN – Florence, Horry, Georgetown, Williamsburg, Clarendon, Sumter, Lee, Darlington, Chesterfield, Marlboro, Dillion, Marion.

Florence County Health Department
145 E Cheves Street, Florence, SC 29506

Phone # (843) 673-6607
Fax # (843) 673-6670

Email peedeeregioncyshcn@dph.sc.gov

OR

Horry County Health Department
1931 Industrial Park Road, Conway, SC 29526

Phone # (843) 915-8806
Fax # (843) 915-6506

Email peedeeregioncyshcn@dph.sc.gov

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

Charleston County Health Department
3685 Rivers Ave., Suite 201, North Charleston, SC 29405

Phone # (843) 953-4514 **or** (843) 953-1257
Fax # (843) 953-1276

Email lccyshcn@dph.sc.gov

CYSHCN SERVICES REQUEST FORM

Instructions for Completing 4290-ENG-DPH

PURPOSE

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

INSTRUCTIONS

Person submitting the request will:

a. Enter the name of the individual being referred;
b. Enter the date of birth of the individual being referred;
c. Add the birth sex of the individual being referred;
d. Enter the parent's/guardian's name of the individual being referred;
e. Enter the primary language spoken by the individual and/or family;
f. Enter the primary phone number for the individual or family;
g. Enter the primary email address for the individual or family;
h. Enter the diagnosis(es) and/or ICD code(s) of the individual being referred;
i. Enter the address of the individual being referred, including county;
j. Select the services requested via checking the appropriate box;
k. Select the appropriate insurance coverage for the referred individual, and enter the type of insurance and plan/member ID if applicable;
l. Enter the name of the Agency providing the referral;
m. Enter the name of the person completing the referral;
n. Enter the referral entities phone number and date of completion;
o. Forward the referral to the appropriate regional office listed on page 2.

DPH Care Coordinator:

a. Will enter referral disposition and any relevant notes in the section titled referral disposition;
b. Return form to the person submitting the request.

OFFICE MECHANICS & FILING

This hardcopy form should be completed, scanned into the electronic health record (EHR) under Referral Form Image Type, and securely stored for three (3) months after scanning. Once the 3-month retention period has been met and quality review has been completed, an ARM13 destruction request should be submitted and approved prior to disposal of the paper original form. Comprehensive Adult (08498) or Comprehensive Minor (08499) medical record retention applies.