



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SPECIAL HEALTH CARE NEEDS
PROVIDER APPLICATION

1. VENDOR NUMBER
2. DEPARTMENT AGREEMENT NUMBER

3. BUSINESS/AGENCY NAME	4. FEDERAL ID OR SOCIAL SECURITY NUMBER
-------------------------	---

5. LOCATION ADDRESS	6. TELEPHONE	7. FAX NUMBER
---------------------	--------------	---------------

8. CITY	STATE	ZIP CODE	9. COUNTY
---------	-------	----------	-----------

10. PAYMENT MAILING ADDRESS (IF DIFFERENT FROM LOCATION ADDRESS)	11. TELEPHONE
--	---------------

12. CITY	STATE	ZIP CODE
----------	-------	----------

13. IS YOUR AGENCY A MEDICAID PROVIDER?
 YES NO IF YES, ENTER NUMBER(S) _____


14. TYPE OF SERVICES YOU WILL PROVIDE TO SHCN PARTICIPANTS (SEE SECTION 17)

Complete this section if you wish to provide services for the Adult Head Injury Service.
 Check services you can provide:

<input type="checkbox"/> Adjustment Counseling	<input type="checkbox"/> Special Instruction
<input type="checkbox"/> Behavioral Assessment & Consultation	<input type="checkbox"/> Supported Employment/Following Along
<input type="checkbox"/> Neuropsychological Evaluation & Consultation	<input type="checkbox"/> Transitional Home & Community Support
<input type="checkbox"/> Pre-Vocational/Pre-Employment Training	<input type="checkbox"/> Transportation
<input type="checkbox"/> Socialization Skills Training	

15. CERTIFICATION

By signing this form you are stating that you/your staff are licensed/certified to provide the services that you have selected. Your signature also indicates that you agree to comply with the policies, procedures, and billing guidelines of Special Health Care Needs. Failure to abide by these policies and procedures could result in the termination of your contract with the Department of Health and Senior Services and the recovery of funds paid to you for services rendered. You may access the Provider Billing Guidelines at https://www.dhss.mo.gov/shcn/0TOC_0_0.NEW.htm or by submitting a written request for a copy of the guidelines.

I CERTIFY THAT THE INFORMATION I PROVIDED IS ACCURATE AND TRUE.	16. SIGNATURE OF APPLICANT/AUTHORIZED REPRESENTATIVE 
---	---

17. SPECIALTY SERVICES

Complete this section if you wish to provide services for children with special health care needs.
Check the services you can provide:

Dentistry

- Endodontist
- General
- Oral Surgeon
- Orthodontist
- Pedodontist
- Periodontist
- Prosthodontist

Durable Medical Equipment

- Augmentative Communication Device & Repair
- DME Equipment & Repairs
- Hearing Aid Service & Repairs
- Orthotics
- Prosthetics
- Supplies

Emergency Transportation

- Emergency Transportation Services

Evaluations & Therapy

- Audiologist
- Augmentative Communication Evaluation Team
- Cleft Lip & Palate Management Team
- Occupational Therapist
- Physical Therapist
- Registered Dietitian
- Respiratory Therapist
- Speech Language Pathologist/Speech Therapist

Facility/Treatment Center

- Ambulatory Surgery Center
- Emergency Care Center
- Hospital Services (Inpatient)
- Hospital Services (Outpatient)

Interpreter

- Interpreter Services

Pathology

- Laboratory Services

Pharmacy

- Pharmacy Services

Psychologist

- Psychological Testing and Evaluation

Physician

- Anesthesiology
- Cardiology
- Cardiology, Pediatric
- Chiropractor
- Dermatology
- Dermatology, Pediatric
- Emergency Medicine
- Endocrinology
- Gastroenterology
- Gastroenterology, Pediatric
- Genetic (Eval)
- Hematologist
- Medicine, Internal
- Medicine, Pediatric Rehabilitation
- Medicine, Physical and Rehabilitation
- Nephrology
- Nephrology, Pediatric
- Neurology
- Neurology, Pediatric
- Ophthalmology
- Orthopaedic
- Orthopaedic, Pediatric
- Pathology
- Pediatrics
- Pediatrics, Developmental
- Proctology
- Pulmonary
- Pulmonary, Pediatric
- Radiology
- Rheumatology
- Rheumatology, Pediatric
- Surgery, Abdominal
- Surgery, Cardiovascular
- Surgery, Colon and Rectal
- Surgery, Facial Plastic
- Surgery, General
- Surgery, Hand
- Surgery, Head and Neck
- Surgery, Maxillocranial
- Surgery, Neurosurgery
- Surgery, Orthopedic
- Surgery, Otolaryngology
- Surgery, Pediatric
- Surgery, Plastic & Reconstructive
- Surgery, Thoracic
- Surgery, Urological
- Surgery, Vascular
- Urology

18. COUNTIES OF SERVICE (PLEASE PROVIDE THE COUNTY/COUNTIES YOU WILL BE PROVIDING SERVICES IN.)

**SPECIAL HEALTH CARE NEEDS
PROVIDER APPLICATION (CC-35)
INSTRUCTIONS**

- | | |
|--|---|
| 1. VENDOR NUMBER | SHCN use only. |
| 2. DEPARTMENT AGREEMENT NUMBER | SHCN use only. |
| 3. BUSINESS/AGENCY NAME | Enter the complete name of the agency/business. |
| 4. FEDERAL ID OR SOCIAL SECURITY NUMBER | Enter the Federal Tax identification number or the Social Security number which the provider uses to file federal income tax. |
| 5. LOCATION ADDRESS | Enter the street address of the agency/business. |
| 6. TELEPHONE | Enter the telephone number of the agency/business address. |
| 7. FAX NUMBER | Enter the fax number of the agency/business. |
| 8. CITY, STATE, ZIP | Enter the city/state/zip of the agency/business address. |
| 9. COUNTY | Enter the county the agency/business is in. |
| 10. PAYMENT MAILING ADDRESS | Enter the address where payment should be mailed if different from the agency/business address (PO Box, street, etc.). |
| 11. TELEPHONE | Enter the telephone number at the payment mailing address if different from the agency/business telephone number. |
| 12. CITY, STATE, ZIP | Enter the city/state/zip where payment should be mailed if different from the agency/business address. |
| 13. IS AGENCY A MEDICAID PROVIDER? | Indicate if you are an approved Medicaid Provider. If yes, indicate the agency's Medicaid number. |
| 14. TYPE OF SERVICES | Indicate the type of services you will provide for the Adult Head Injury program. |
| 15. CERTIFICATION | Review certification paragraph. |
| 16. SIGNATURE OF APPLICANT/AUTHORIZED REPRESENTATIVE | Enter original signature of Authorized Representative. |
| 17. SPECIALTY SERVICES | Indicate the type of services you will provide for the Hope program. |
| 18. COUNTIES OF SERVICE | Indicate county(ies) you will be providing service in. |