

Philadelphia Coordinated Health Care
Special Services Fund Application

Please complete and return to the attention of the Health Care Community Outreach Specialist:
 123 S. Broad Street, 22nd Floor, Philadelphia, PA 19109 (215) 546-0300 or FAX: 215-790-4976

Name of Person Completing Form:	Telephone #:
Name of Individual:	Date of Birth:
Address:	Social Security #:
Agency Name:	Agency Phone #
Agency Contact:	County Case Manager Name:
Member of Plaintiff Class? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, <input type="checkbox"/> Pennhurst <input type="checkbox"/> Dual (Penn/Emb)	
Type of Residence: <input type="checkbox"/> CLA <input type="checkbox"/> ICF/MR <input type="checkbox"/> Life Sharing <input type="checkbox"/> Own Home <input type="checkbox"/> Boarding Home <input type="checkbox"/> Domiciliary Care <input type="checkbox"/> Semi-independent <input type="checkbox"/> Independent <input type="checkbox"/> PLF <input type="checkbox"/> Other: _____	
Medicare Part D/Prescription Drug Plan - Name/ID Number _____	
Medical Assistance, HMO Type: <input type="checkbox"/> AmeriChoice <input type="checkbox"/> Keystone-Mercy <input type="checkbox"/> HealthPartners	
Medical Assistance (ACCESS) #:	
Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", Membership #: _____ <input type="checkbox"/> Part A? <input type="checkbox"/> Part B?	
Private Health Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", Insurance Company Name: Policy Number:	
Primary Care Physician Name:	PCP Phone:
Primary Care Dentist Name:	PCD Phone:
Reason for last dental visit:	Date of last dental visit:
DESCRIBE SERVICES REQUESTED:	
Is treatment statement (description of service(s) from PCP attached? <input type="checkbox"/> Yes <input type="checkbox"/> No Has written supporting documentation been attached from medical insurer verifying decline of coverage for service(s) requested? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the individual or agency able to contribute funds toward payment of the requested service(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", provide amount here: \$ _____	
COMMENTS: (use reverse side if additional information is needed)	
To the best of my knowledge, all information contained in this form is accurate:	Print Name & Signature:
FOR USE BY PCHC:	
Date Processed:	PCHC Staff Responsible for Follow-up:
Supervisory Approval:	Approval for Disbursement (Director):
Type of Action Taken:	