Child Health Intake Form (CHIF)

DOH 141-184 February 2025

The Children and Youth with Special Health Care Needs (CYSHCN) Program is funded by the state and federal resources and offered through (**Your Organization**). We use the information on this form to understand how to serve you better and get a count of the number of CYSHCN being served across the state. We share this information with the Health Care Authority to provide additional care coordination through your current Managed Care Organization. ****required information**

Child's Name: (Please print clearly)	**Child's Date of Birth:**	**Gender (please circle)** **M or F or Non-Binary**	
Address: **City:** **State:**		**Zip Code:**	**County:**

Insurance Coverage	Race
Insurance Coverage: please check all that apply Apple Health (Medicaid or Provider One) ****Do you pay a premium each month? ___ Yes ___ No** ****PROVIDER ____________________________WA** ☐ Private insurance ☐ Tri-Care (CHAMPUS – military) ☐ None	**Race:** ☐ Asian or Asian American ☐ Black ☐ Native American ☐ Alaskan Native ☐ Hispanic or Latinx ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Not Listed ☐ Prefer not to disclose
If you are not on Apple Health, you may be eligible for free or low-cost coverage, including secondary coverage and help with premium payment for private insurance. **Check the income limits to confirm if you qualify.**	

Diagnosis I	**ICD-10 Code**	**Diagnosis II**	**ICD-10 CODE**

My child receives services through these state and community agencies:	**Please check which agency referred you to the children and youth with special health care needs programs or that you are involved with:**
☐ WIC	☐ (Name Local Organization)
☐ Social Security Income or Disability	☐ (Name Local Organization)
☐ Developmental Disabilities Administration	☐ (Name Local Organization)
☐ Children's Hospital (includes Mary Bridge)	☐ (Name Local Organization)
☐ Foster Care	☐ (Name Local Organization)
☐ Public Schools	☐ (Name Local Organization)
☐ Early Support for Infants and Toddlers	

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.