Mail to: PO Box 9, 315 Lehman Avenue, Suite C Topeka, IN 46571 OR Fax to: 260-593-0116

NBS Grant Data Sheet

Print all information in blue or black ink.

Patient's Name: Last: First: Middle:

Date of Birth:

Name of Responsible Party(if other than patient/who pays the bills?):

Current Address (number and street):

City: State: ZIP Code:

Telephone-Home: Work: Cell:

What is the medical condition?:

Please check those that apply:

☐ Medicaid

☐ Children's Special Health Care Services

☐ Commercial Insurance

Participation agreement: The CHC and its staff strive to provide or connect its patients with medically necessary supplies. As part of the mission of the CHC we strive to make medical care and treatment affordable. Providing a service or product for a reduced cost is a community benefit. The supplies provided through this service should not be shared or resold. Doing so is grounds for dismissal. This service is not intended to compete with other businesses or programs that provide medical products. Participation is voluntary on the part of the patient and the patient's cargiver. Information supplied in this or supporting documents will be treated in a confidential manner and used solely for the purpose of patient assistance.

By signing below, I understand the participation agreement and certify that the information provided on this application is true and accurate to my knowledge, and agree that any Newborn Screening (NBS) services provided by the CHC may be paid for through NBS grant funding at the discretion of the CHC. I understand that coverage is in effect until the child turns 4 years old. I acknowledge that the original costs for the items have been provided to me. I am aware of and understand the recommended treatment plan.

*Signature:*____________________ *Date:*__________

By signing below, I verify that I have received the information about the NBS grant funding, and have chosen not to participate.

Signature: ____________________ *Date:*__________