NAME OF HEAD OF HOUSEHOLD	PHONE ( )
ADDRESS	

LDSS-2400 (11/98)

REQUEST FOR CHILD/TEEN HEALTH PROGRAM SERVICES

(List all members of the household and check the services you request for each)

FOR AGENCY USE ONLY	CASE NO.
TYPE OF APPLICATION ☐ New ☐ Reopened ☐ Recertified ☐ Other	Date of Eligibility Determination Mo. Day Yr.

Individual Name	Recipient Identification Number	Sex		Birth Date			C/THP Services				Dental Services				Family Planning		Prenatal Care Serv.*	
							Check if Under 21			If Child has a Regular Physician or Clinic Give Name and Address	Check if Under 21			If Child has a Regular Dentist or Dental Clinic Give Name and Address	Request Services ?	Request Asst. in Obtaining Services	Request Services ?	Request Asst. In Obtaining Services
		M	F	Mo.	Day	Yr.	Request C/THP Exam?	Req. DSS To make Appt.?	Request Trans Asst.?		Request Dental Exam?	Req. DSS To make Appt.?	Request Trans Asst.?					
							☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
							☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
							☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
							☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
							☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
							☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
							☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

I give permission to the Department of Social Services to release C/THP information to other agencies/individuals for the health care of my child and myself.

(Signature of Parent/Guardian, Recipient) (Date)

REMARKS

*Does **not** replace LDSS-3833, Prenatal Care Referral Form

SIGNATURE OF HEAD OF HOUSEHOLD	DATE
SIGNATURE OF AGENCY WORKER	DATE