1301 International Pkwy.
Suite 400
Sunrise, FL 33323

SUNSHINE HEALTH CHILD WELFARE SPECIALTY PLAN

Care Grant Expanded Benefit Request Form

Date: ______________________________

Name of CBC staff submitting form: ______________________________

Name of CBC: ______________________________

Address of CBC: ______________________________

Phone number of CBC: ______________________________

Post Adoption ONLY

Name of Parent: ______________________________

Parent phone #: ______________________

Address of Parent: ______________________________

*Note: Completion of a W-9 form is required by the parent to process the care grant. Payment is made directly to the parent.

Member Name: ______________________________

Member Medicaid Number: ________________ **Member DOB:** ________________

1. **List items/services being requested:**

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2. **Please describe how this request is for a social, physical, or education activity that will benefit the child.**

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Description of supporting documentation submitted (Care Grant Requests submitted to Sunshine Health without supporting documentation cannot be processed.)

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Total benefit amount requested: $ ________________________________

- **Preferred method is to email form & supporting documentation to caregrants@centene.com.**
- **The form and supporting documentation can be faxed to 1-855-478-2890**
- **The form and supporting documentation may be mailed to: Sunshine Health 1301 International Parkway, Suite 400, Sunrise, FL 33323. Attention: Child Welfare Specialty Plan Department**
- **Please send any questions via email to caregrants@centene.com.**

Sunshine Health Internal Use Only:

☐ Approved ☐ Partial Approval ☐Denied

Signature of Director of Operations, Child Welfare Programs:

____

If partially approved or denied, reason: ________________________________

Date of determination: ____

Signature of VP, Child Welfare Programs: ______________________________