Primary Caregiver Assessment of Child's Health and Social Status

Applicant/child's name: _____ Medicaid ID #: _____

Purpose

The primary caregiver of the above named child must complete this form. The information provided about the child will be used in the determination of medical eligibility for the Children's Community Alternative Disability Program. Your social worker will send the completed form to the Medical Review Team that is responsible for making the medical eligibility determination. Medicaid is requesting that you provide medical and social information that will help in the decision about whether your child meets the requirements of the program.

Instructions:

This form should be completed and submitted with your application form. Please complete all questions. If a question does not apply to your child please write "N/A" in that area.

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1. Identifying Information

_____ _____

Child's full name Date of Birth

_____ _____

Nicknames for Child used by family/friends Place of birth (hospital, city, State)

Weight:

_____lbs.____ozs. Problems experienced during pregnancy with this child:_____

_____

_____

Other persons living in the household:

Name	Relationship	Age

2. Information about the child's disability:

   A. What was the date of the onset of the disability? _____

   B. Please describe in detail the medical diagnosis and symptoms of the child for whom you are applying. How are his/her abilities limited?

   _____
   _____
   _____
   _____
   _____
   _____

   C. Is there any history of similar medical problems in the family? Yes____ No____
   If yes, please explain:

   _____
   _____

3. Information about the child's medical history:
   Give concise and specific answers about your child's medical history.

   A. Has the child any surgeries related to his/her current medical condition?
   Yes____ No____ If Yes, explains:

   _____
   _____
   _____

   B. What was his/her response to the surgery? Did it substantially improve his/her condition?

   _____
   _____

   C. Has the child had any therapies? Yes____ No____ If Yes, describe:

   _____
   _____

   D. What was the response to therapy? Did it substantially improve his/her condition?

   _____
   _____

   E. Has any special exercise been described for the child? Yes____ No____ If Yes, describe:

   _____
   _____

F. What was his/her response to exercise? Did it substantially improve his/her condition?

_____

_____

G. Is the child on a normal diet? Yes____ No____ If no, describe the special diet that has been prescribed: _____

_____

H. Describe **all** medications that the child takes and the frequency that those medications are used:

Name of medication	Dosage	How often taken

I. What equipment, appliances or supplies does your child need on a routine basis to function (such as eyeglasses, wheelchair, braces, cast, crutches, cane, prosthetics, etc.)?_____

_____

_____

Does your child use any special adaptation in order to function? Yes____ No____

Any assistive devices? (List) _____

_____

Special Technology? (List) _____

_____

J. Is your child incontinent? Yes____ No____

K. Does he/she require:

	Yes	No
Catheter?	_____	_____
Colostomy care?	_____	_____
Gastrostomy care?	_____	_____
Tracheotomy care?	_____	_____
Preventative or decubitus care?	_____	_____
Tube feeding?	_____	_____

Any other care not described before in your answers?

_____

_____

L. List any current (within the past 6 months) or pending evaluations, assessments, x-rays, medical tests or laboratory studies:

Name of Procedure	Date done or scheduled

M. List any recent period(s) of hospitalization related to the child's current condition. Include the name(s) of the hospital(s), date(s) of hospitalization(s), and specify the reason the child was hospitalized:

Hospital Name & Location	Dates Hospitalized	Reason

N. What is the current emotional state of the child? How does the child view himself/herself?

_____

_____

_____

_____

O. Does your child receive counseling? Yes____ No____

How often?_____

For what problem?_____

4. Information about the child's current abilities and limitations:

This section is for the primary caregiver's statement about the effect of the physical and/or mental illness or impairment on the child's ability to function. Compare the child's functional abilities now with the level of functioning prior to his/her disability.

_____

_____

_____

_____

_____

_____

A. Does your child display or have any problems with the following:

	Yes	No
emotional withdraw	_____	_____
bed wetting	_____	_____
eating disturbance	_____	_____
sleep disturbance	_____	_____
impulsivity	_____	_____
fire starting	_____	_____
eating disorder	_____	_____
concentrating	_____	_____
poor concentration & attention	_____	_____
temper tantrums	_____	_____
negativity & defiance	_____	_____
lying	_____	_____
cheating	_____	_____
stealing	_____	_____
physical aggression	_____	_____
self injurious behaviors	_____	_____
destruction of property	_____	_____
functioning in school	_____	_____
substance abuse	_____	_____

B. Does the rest of the family make adjustments to accommodate child's impairment?
Yes____ No____
Explain:_____
_____
_____

C. How does your child get along with other family members?
_____
_____
_____
_____

D. Describe your child's friends:
_____
_____
_____
_____
_____

5. Has your child ever been tested or evaluated by any of the following agencies or organizations? Submit copies of applicable evaluations.

	Type of evaluation or testing from agency:
Division of Public Health	
Child Watch	
WIC program	
Division of Developmental Disabilities Services	
Division of Alcohol & Drug Abuse	
Division of Visual Impairment	
Speech & Hearing	
Division of Vocational Rehabilitation	
Division of Child Mental Health	
Special Needs Agency	
United Cerebral Palsy	
Independent Living	

6. Information about the child's medical providers:

   List names of doctors, clinics, therapists, home health agencies, and other medical providers that are providing care to your child. Indicate the date last seen by each provider, the frequency of the visits and the reason your child is seeing that provider related to the current medical condition.

Provider Name	Date last seen	Frequency seen	Reason

7. Information about the child's social situation:

   A. What are the child's favorite toys, games, activities, interests or hobbies?

   B. Does your child participate in any schools, church, sports or community activities?
   Yes____ No____ If yes, describe:

   C. What are your child's likes/dislikes?

   D. If your child is a teenager, what are his/her plans for the future?

E. Does your child participate in home schooling? Yes____ No____

F. Does your child receive remedial assistance, tutoring from the community? Yes____ No____

G. Is your child in a self-contained or regular classroom? Yes____ No____

H. How many days of school did your child miss?_____
In the past month?_____
In the past year?_____

I. Is child in special education program? Yes____ No____
When was the most recent IEP done?_____ If applicable, submit a copy of IEP.

8. Medical Insurance Information:
Describe all health insurance coverage that your child has. **Medicaid** ☐ **CHIP** ☐

Insurance Company:_____
Policy Holder:_____
Policy/Group#(s):_____
Policy Holder's Employer:_____
% covered by Insurance:_____
Comments:_____
_____
_____

9. Have you ever applied for Supplemental Security Income for your child?
Yes____ No____ If yes, indicate the dates and disposition of the application.

Date(s) applied for SSI	Approved (check one)	Denied
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Why are you applying for the Children's Community Alternative Disability Program for your child?

_____
_____
_____
_____
_____

This form was completed by:_____

Phone:_____

Relationship to the applicant:_____

Date completed:_____