

**PART I**

**Child's Medical & Social Information**

(to be completed by parent/guardian/care-giver)

1. Name \_\_\_\_\_ SSN \_\_\_\_\_  
Age \_\_\_\_\_ Sex \_\_\_\_\_ MEDS PN \_\_\_\_\_ Parish \_\_\_\_\_
2. Name of person providing information \_\_\_\_\_  
Relationship to child \_\_\_\_\_
3. Who else lives in the home with the child? \_\_\_\_\_  
\_\_\_\_\_
4. Describe this child's disability and how it affects his or her ability to do the things most children do.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. When did the disability begin? \_\_\_\_\_
6. Is the child in school?  Yes  No If **Yes**, please give the following information.  
Name of school: \_\_\_\_\_  
School address: \_\_\_\_\_  
School Telephone: \_\_\_\_\_ Teacher's Name: \_\_\_\_\_  
Grade Level: \_\_\_\_\_  Regular Classes  Special Education  Resource Classes
7. Does this child have any special problems in school?  Yes  No If **Yes**, please describe.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. If this child is school-age but is **not** in school, please explain why he or she is not in school.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. Please describe the way this child spends an average day from the time he or she gets up until bedtime. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. List any activities in which the child participates (sports, hobbies, school activities, scouting, clubs, etc.) and how often he/she participates. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Have there been any changes in the child's activities or behavior since his or her condition began?  
 Yes  No If **Yes**, please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
12. Does the child help with any household chores?  Yes  No If **Yes**, what are the chores?  
\_\_\_\_\_  
How often are they done? \_\_\_\_\_  
How well are they done? \_\_\_\_\_  
How much supervision is needed? \_\_\_\_\_
13. How does the child behave with adults (parents, other family members, teachers, neighbors)? Please give examples. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14. Does the child's condition cause pain or discomfort?  Yes  No If **Yes**, how does this affect his/her daily activities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
15. Where does the child receive medical treatment?  
 Mental Health Clinic  Private Physician  Clinic  Hospital  Other Source
16. How often does the child visit the doctor or receive medical treatment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
17. What medical records are available (for the 12 months preceding application) to document the child's disability? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
18. Has the child undergone medical tests by a medical specialist or anyone else not listed above?  
 Yes  No If **Yes**, by whom or where, what test, and approximately what date? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. Is the child taking medication?  Yes  No If **Yes**, please complete the following.

Name of Medication	Prescription		Dosage/How Often Taken
	Yes	No	

20. How does this medication affect the child? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

21. If there is anyone else (friends, relatives, counselor) who can provide information about the child's condition, please provide his/her name, phone number and relationship to the child.

Name	Phone Number	Relationship

22. Has this child applied for Supplemental Security Income (SSI) benefits?  Yes  No  
 If **Yes**, when? \_\_\_\_\_  
 What is the status of the application?  Approved  Pending  Appealed  Denied  Terminated  
 If denied OR terminated, when? \_\_\_\_\_ Why? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

23. Tell us any other information that you think we need to know about this child. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Phone \_\_\_\_\_

**PART II**

**Certification Information**

(to be completed by Medicaid office staff)

1. Application Date: \_\_\_\_\_ **OR** Redetermination Date: \_\_\_\_\_
  
2. Is retroactive medical eligibility being requested?  Yes  No  
If **Yes**, for which months? \_\_\_\_\_
  
3. What period of eligibility is being requested? \_\_\_\_\_  
\_\_\_\_\_
  
4. Is this applicant/recipient an ineligible or illegal alien?  Yes  No
  
5. Specify the Medicaid program for which a disability decision is being requested:  
 Affected Child  
 MNP  
 LTC/Waiver  
 Other \_\_\_\_\_

\_\_\_\_\_  
Signature of Agency Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervisor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number of Supervisor

