Identification Tool

For Children with Complex Special Health Care Needs

Child's Name:________________________ Medicaid ID number: ___________________________

Child's Address: ____________________________ Health Plan: __________________________________

Child's Phone: ______________________________ PCP: ____

1	Is your child restricted or prevented in any way in his/her ability to do the things most children of the same age can do?	**YES** (If YES, go to 1A)	**NO** (If NO, go to 2)
1A	Is this because of ***ANY*** medical, behavioral or other health condition lasting or expected to last for ***at least*** 12 months?	**YES**	**NO**
2	Does your child currently need or use any of these (check all that apply): *(Note: A YES for **ANY** of the items listed below (a-d) will qualify as a YES response for question 2.)*:	**YES** (If Yes to <u>any</u> (a-d) listed below go to 2A)	**NO** (If no to <u>all</u>, go to 3)
	a. Medicines prescribed by a doctor other than vitamins		
	b. Mental health treatment or counseling		
	c. Physical, speech or occupational therapy		
	d. Special equipment (*<u>for example</u>*: to help with moving, Walking, talking, hearing, breathing, feeding, personal care, etc.)		
2A	Is this because of ANY medical, behavioral or other health condition lasting or expected to last for **<u>at least</u>** 12 months?	**YES**	**NO**
3	Does your child (or child's name) currently have these (check all that apply): *(Note: A YES for **ANY** of the items listed below (a-d) will qualify as a YES response for question 3.)*:	**YES** (If Yes, go to 3A)	**NO** (If No, go to 4)
	a. Life-threatening allergic reactions?		
	b. A special diet prescribed by a doctor?		
	c. A learning or behavioral difficulty for which he or she receives professional treatment or counseling?		
	d. Early Childhood Intervention (ECI), Special Education or Rehabilitation services?		
3A	Is this because of ***ANY*** medical, behavioral or other health condition lasting or expected to last for **at least** 12 months?	**YES**	**NO**
4	Does your child (or child's name) need or use more medical care, mental health or education services than usual or routine for most children of the same age?	**YES** (If Yes, go to 4A)	**NO**
4A	Is this because of ***ANY*** medical, behavioral or other health condition lasting or expected to last for ***at least*** 12 months?	**YES**	**NO**

<u>ADDITIONAL INFORMATION:</u>

Please provide diagnosis information, if available.

Primary: ____

Secondary: ____

Note: This tool for SB1165 CCSHCN Pilot purposes only. *(Adapted from FACCT, August 13, 1999)*