Clear Form

Minnesota Department of **Human Services**

DHS-6126-ENG 6-10

State Medical Review Team

Children's Disability Worksheet

CHILD'S FIRST NAME	LAST NAME	MIDDLE INITIAL

PMI NUMBER	COUNTY OF SERVICE	DATE OF BIRTH	CHILD'S CURRENT HEIGHT	WEIGHT

PARENT(S)/GUARDIAN ADDRESS				
CITY	STATE	ZIP CODE	PHONE NUMBER ( )	FAX NUMBER ( )

PRIMARY CARE PHYSICIAN/HEALTH CARE HOME	PHONE NUMBER ( )	FAX NUMBER ( )

ADDRESS	CITY	STATE	ZIP CODE

PARENT(S)/GUARDIAN SIGNATURE	DATE

To the parents:

Please take this opportunity to describe for the State Medical Review Team reviewers (physicians/psychologists/nurses/social workers) how your child's medical/psychological condition(s) affect(s) his/her life in terms of ability to function. We need to know if the child can perform activities of daily living (e.g., bathing, dressing, eating); what behaviors are disruptive at home, in school and in the community; amount of supervision required; services needed; medications used; doctors/therapists seen; and, equipment required. This information will assist us in determining if your child has a disability that meets the standards set by the Social Security Administration, and if the level of care your child requires is equal to that provided in an institution.

1. From the list below, please check all the diagnoses that apply to your child.

- ☐ 1. ADD/ADHD
- ☐ 2. Allergies
- ☐ 3. Asthma/Respiratory
- ☐ 4. Arthritis/**Juvenile**
- ☐ 5. Autism Spectrum
- ☐ 6. Behavior Disorder
- ☐ 7. Brain Injury, Traumatic
- ☐ 8. Cancer
- ☐ 9. Cerebral Palsy
- ☐ 10. Cleft Lip and/or Palate
- ☐ 11. Cystic Fibrosis
- ☐ 12. Developmental Disorder
- ☐ 13. Diabetes/**Juvenile**
- ☐ 14. Down Syndrome
  Other syndrome _____
- ☐ 15. Hearing Loss
- ☐ 16. Heart Condition
- ☐ 17. Hemophilia
- ☐ 18. HIV/AIDS
- ☐ 19. Immune Deficiency
- ☐ 20. Kidney/Urinary Condition
- ☐ 21. Learning Disability
- ☐ 22. Developmental Disability
  - ☐ Mild
  - ☐ Moderate
  - ☐ Severe
- ☐ 23. Mood Disorder
- ☐ 24. Muscular Dystrophy
- ☐ 25. Orthopedic Condition
- ☐ 26. Paralysis or Weakness
- ☐ 27. Seizure Disorder
  - ☐ Controlled
  - ☐ Uncontrolled

  Number per month _____
- ☐ 28. Severe Emotional Disorder
- ☐ 29. Speech/Language Disorder
- ☐ 30. Spina Bifida
- ☐ 31. Vision Loss
- ☐ 32. Other Disorder or Condition:
  _____
  _____
  _____

33. Was your child premature?
☐ Yes ☐ No
If yes, how many weeks early?
_____ weeks

34. Weight at birth _____

Comments
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

2. Briefly describe your child's developmental milestones:

_____
_____
_____
_____
_____

3. Describe how your child's challenges affect your child and family:

_____
_____
_____
_____
_____

4. For each of the activities of daily living listed below, please check all of the categories that best fit your child.

Activity	Age-appropriate	Independent	Needs verbal cues	Needs physical cues	Totally dependent	Refuses to comply	Need to monitor	Has skill but takes extra time
Understanding others	☐	☐	☐	☐	☐	☐	☐	☐
Talking	☐	☐	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐	☐	☐
Eating/drinking	☐	☐	☐	☐	☐	☐	☐	☐
Using the toilet	☐	☐	☐	☐	☐	☐	☐	☐
Bathing/showering	☐	☐	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐	☐	☐
Grooming	☐	☐	☐	☐	☐	☐	☐	☐
Learning or completing tasks at home or school	☐	☐	☐	☐	☐	☐	☐	☐

5. Level of Function/Interactions and Relationships.

In each of the areas listed, please check the box that most accurately describes your child's ability to interact with others, and form and maintain relationships.

Area	No or few social skills	Limited ability to interact/difficult interactions	Average social skills	Above average social skills	Excellent social skills
Family	☐	☐	☐	☐	☐
Friends	☐	☐	☐	☐	☐
School	☐	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	☐
Community	☐	☐	☐	☐	☐

6. Supervision Needs.

Because of physical or emotional problems, does your child need to be watched more closely than average children of the same age? ☐ Yes ☐ No

If yes, what level of supervision does your child need? ☐ Moderate ☐ Substantial ☐ Intense

During the last school year, how many days did your child miss school because of his/her special health needs? _____ days

How many days in the last 12 months has your child spent in the hospital? _____ days

7. Therapy and related services. Please fill in the blanks for any service(s) your child received in the **last 12 months**.

Behavioral training		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Developmental pediatrician		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Neurologist/neurosurgeon		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Neuropsychologist		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Occupational therapist		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Orthopedist		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Physical therapist		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Physician exam/check-up		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Physician (visit for illness)		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )

Psychiatrist (evaluation)		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Psychiatrist (therapy)		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Psychologist (evaluation)		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Psychologist (therapy)		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Rehab. physician		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Respiratory therapist		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Social worker (evaluation)		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Social worker (therapy)		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Speech/language therapist		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )
Other (please explain)		
PROVIDER NAME		LAST DATE SEEN
PROVIDER ADDRESS	PHONE NUMBER ( )	FAX NUMBER ( )

8. Medications and Special Diets.

Does your child currently need medication or a special diet? ☐ Yes ☐ No If yes, please provide the information below.

Prescription Medications		
Medications	Dosages	Times Given Per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
Over-the-counter Medications Recommended by a Physician		
Medications	Dosages	Times Given Per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
Special Diet or Special Formula		
_____		
_____		
_____		

9. Hospital/Emergency care.

Please check any of the following services your child received in the **last 12 months** and the dates seen.

Services Received	Date(s)
☐ Emergency room visits	
☐ Emergency transportation (ambulance, helicopter, etc.)	
☐ Hospital admission (planned)	
☐ Hospital admission (unplanned)	
☐ Same day or outpatient hospital procedures	

10. Equipment and supplies.

Below is a list of equipment and supplies which special needs children may require. Please check the kinds of equipment or supplies your child **currently uses**.

Type of Equipment	My Child Uses
☐ **Adaptive equipment** (eating utensils, special car seat, recreational items)	
☐ **Assistive technologies** (learning aids, devices to assist with speech or daily living)	
☐ **Diapers** or other incontinence supplies	
☐ **Disposable supplies** (distilled water, bandages, gloves, syringes, tubing)	
☐ **Durable medical equipment** (wheelchairs, nebulizers, walkers)	
☐ **Hearing aids or eyeglasses**	
☐ **Orthotics or prosthetics** (braces, artificial limbs, other)	
☐ **Respiratory equipment** (ventilator, percussive vest)	

11. Home Care.

Did your child receive home-care services in the **last 12 months**? ☐ Yes ☐ No If yes, please provide the information below.

Services (check all that apply)	Hours/weeks Authorized	Hours/weeks Received	Child's Age When Service Began
☐ Home health aide			
☐ PCA services			
☐ Skilled nurse services (RN or LPN)			

12. Counseling/psychotherapy services.

Some children with special health needs or their families receive counseling services. Did anyone in your family receive counseling services in the last 12 months? ☐ Yes ☐ No If yes, please provide the information below.

Who Received Counseling/Psychotherapy?	How Many Times Per Month?
☐ Child	
☐ Parents	
☐ Brothers/sisters	
☐ Family	

13. Case management.

Are there people who coordinate, locate, or manage the services your child receives? ☐ Yes ☐ No
If yes, who does this? (check all that apply)

☐ Birth–3 service coordinator	☐ Home-care agency	☐ Parent	☐ Other
☐ County case manager	☐ Hospital staff	☐ Physician	
☐ County public health nurse	☐ Insurance company	☐ School	

14. County-based children's mental health services.

Below is a list of services children sometimes receive if they are eligible for county mental health services. Has your child received county-based mental health services **in the last 12 months**? ☐ Yes ☐ No If yes, please check each service your child or family received.

Mental Health Service	How Often Per Month
☐ Assistance in developing independent living skills	
☐ Assistance in developing parenting skills	
☐ Case management	
☐ Crisis assistance	
☐ Day treatment	
☐ Foster care	
☐ Medication management	
☐ Professional home-based family treatment	

15. Respite Care.

In the last 12 months, when you have needed a break from providing care for your child with special needs, were you able to get it? ☐ Yes ☐ No If yes, check all that apply:

Respite Care Services	How Often?
☐ Friend or relative	
☐ Foster care	
☐ ICF/MR facility	
☐ Non-specialized professional care provider	
☐ Specialized professional care provider	
☐ Private, social or religious organization	
☐ Other	

16. School Services.

Does your child have an IEP (Individualized Education Program)? ☐ Yes ☐ No

If yes, when was the IEP last updated? _____ When was the Team Assessment last updated? _____
DATE DATE

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍເຫຼືອຂອງທ່ານ ຫຼື ໂທຣ໌ ຫາຕາມເລກໂທຣ໌ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB2-0007 (1-08)

ADA3 (5-09)

This information is available in alternative formats to individuals with disabilities by calling (651) 431-2493 or (800) 235-7396. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.