SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Disability Report - Child Under Age 19

Send to: SCDHHS - Central Mail
PO Box 100101
Columbia SC 29202-3101

This box for pilot use only
☐ Presumptive Disability
☐ DD Workflow Pilot

*If you need assistance, please call the Healthy Connections Member Contact Center toll free at **(888) 549-0820**.*

FOR DHHS USE ONLY

☐ Child Initial ☐ Retro Only Date of Last Update: _____

Number of pages received and scanned: _____

Household Number: _____ Application Date: _____ Retro: _____

Please fully complete this form and return with the signed Authorization to Disclose Health Information. It is very important that you provide complete addresses and phone numbers for your medical sources. If the form is not completed fully, it will delay the processing of your Medicaid Disability claim.

It is critical that the enclosed Authorization to Disclose Health Information form is signed **IN BLACK INK** by the PARENT OR LEGAL GUARDIAN of the minor child. **If there is a legally appointed representative or power of attorney documentation, please include a copy with your completed and signed form.**

CHILD'S INFORMATION

☐ Male ☐ Female ☐ Prefer Not to Answer

Child's Last Name: _____ Child's First Name: _____ Middle Initial: ___

Child's SSN#: _____ Child's Previous Name (if applicable): _____

Date of Birth: _____ Date of Death (If Applicable): _____

Street Address: _____ City: _____ State: ___ ZIP: _____

PARENT/GUARDIAN INFORMATION

Parent / Guardian: _____ Home Phone: _____

Relationship to Applicant: _____ Cell Phone: _____

Parent / Guardian's Street Address: _____

_____

What is your preferred spoken or written language (if not English)? _____

What is your child's Disability?

Explain how the child's disability affects his/her ability to function. (You may add additional pages, if needed.)

SCHOOL/TRAINING INFORMATION

Is the child currently attending school (or preschool)? ☐ Yes ☐ No

If yes, please complete the following: Current Grade: _____ Primary Teacher's Name: _____

Name of School: _____

Address: _____

Is the child in a special education program? ☐ Yes ☐ No School Phone Number: _____

If yes, please list teacher's name: _____

Is your child currently enrolled in an Early Intervention Program? ☐ Yes ☐ No

If yes, name of program: _____

If you have a copy of student's IEP or IFSP (for children under 3), please include a copy with completed application.

Type of therapy	Number of visits at home	Number of visits at school	Therapist name/agency
Speech			
Physical			
Occupational			
Respiratory			
Other:			

CHILD'S MEDICAL CONDITION

Activities of Daily Living: Please indicate your child's functional level by putting a checkmark in one of the columns for each activity.

Walk	☐ Independent	☐ With Assistance	☐ Is Not Able
Crawl	☐ Independent	☐ With Assistance	☐ Is Not Able
Sit Up	☐ Independent	☐ With Assistance	☐ Is Not Able
Turn/Roll Over	☐ Independent	☐ With Assistance	☐ Is Not Able
Bathing	☐ Independent	☐ With Assistance	☐ Is Not Able
Dressing	☐ Independent	☐ With Assistance	☐ Is Not Able

Functional Level: Please indicate your child's functional level.

Sight	☐ Good	☐ Fair	☐ Poor	☐ None
Hearing	☐ Good	☐ Fair	☐ Poor	☐ None
Speech	☐ Good	☐ Fair	☐ Poor	☐ None

Feeding: Check all that apply.

☐ Oral ☐ Nasogastric tube

☐ Gastrostomy or jejunostomy tube ☐ Parenteral (intravenous) nutrition

Is your child's developmental (functional) level age-appropriate? ☐ Yes ☐ No

If no, what is the development age? _____

Medications: Please provide the following information for all medications that your child takes on a regular basis.

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Equipment and Supplies: Please indicate whether your child needs any of the following items:

☐ Apnea monitor	☐ Prone stander	☐ Nasogastric tubes	☐ Cardiac monitor
☐ Dialysis	☐ Syringes	☐ Walker	☐ Cough Assist Vest
☐ Tracheostomy tubes	☐ I.V. Pump	☐ Suction machine	☐ Body jacket

☐ Gastrostomy tubes ☐ Intravenous fluids ☐ Oxygen ☐ Wheelchair
☐ Braces ☐ Feeding bags/tubes ☐ Feeding pump/pole ☐ Splints
☐ Other: _____

Provider Information

Please list the name and complete address for all doctors, hospitals, and treating facilities where your child has been treated for a medical condition(s) in the last 15 months. Be sure to include the child's primary care doctor and every medical and mental health provider that has treated your child for any of his or her problems since the problems started. A medical or mental health provider may include a doctor, psychologist, therapist, social worker, physical therapist, chiropractor, hospital, emergency room, health center, and clinic from which your child got treatment. You can write on a separate piece of paper if you run out of space. If your child is only getting treatment from one facility, list only that facility.

	Provider's Name	Address	Clinic Name	Reason for Visit	Date Last Seen
1					
					Phone
2					Date Last Seen
					Phone
3					Date Last Seen
					Phone
4					Date Last Seen
					Phone
5					Date Last Seen
					Phone

	Provider's Name	Address	Clinic Name	Reason for Visit	Date Last Seen
6					
					Phone
7					Date Last Seen
					Phone
8					Date Last Seen
					Phone
9					Date Last Seen
					Phone
10					Date Last Seen
					Phone

REMARKS

Use this space to provide additional information that may help make a decision on the child's disability claim.

Please remember to sign and return the Authorization to Disclose Health Information form, Form 921.

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (including large print, braille, audio, accessible electronic formats, and other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, please contact the Americans with Disabilities Act (ADA)/Civil Rights Official by mail at: PO Box 8206, Columbia, SC 29202-8206, by phone at: 1-888-549-0820 (TTY: 1-888-842-3620), or by email at: civilrights@scdhhs.gov.

If you believe SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person, by mail, or via email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.htm