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

☐ Presumptive Disability
This box for pilot use only

*If you need assistance, please call the Healthy Connections Member Services Center toll free at **(888) 549-0820 (TTY 888-842-3620)**.*

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 form in the provided envelope. 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 OR BLUE 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

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: _____

Relationship to Applicant: _____ Phone: - -

Parent / Guardian's Address: ___ _____ City: _____ State: ____ ZIP: _____

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.)

Please provide the name of someone who knows about your child's condition (not a doctor or teacher). Examples: neighbor, grandparent, etc.

Name of Contact: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Relation to Child: _____

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: _____

At school, does the child receive:

☐ Yes	☐ No	Occupational Therapy?	Therapist Name:	_____
☐ Yes	☐ No	Speech Therapy?	Therapist Name:	_____
☐ Yes	☐ No	Physical Therapy?	Therapist Name:	_____
☐ Yes	☐ No	ABA Therapy?	Therapist Name:	_____
☐ Yes	☐ No	Other Services?	Service Provider Name:	_____

If you have a copy of student's IEP, please include a copy with completed application.

Does the child attend a day care or after school program? ☐ Yes ☐ No

Name of Program: _____ Type of Program: _____

Phone Number: _____ - _____ - _____ Teacher/Program Provider: _____

Street Address: _____ City: _____ State: ____ ZIP: _____

Please provide a complete address for all medical and service providers so we may request medical educational and treatment records. If you need additional space, use the "remarks" section or attach additional pages.

MEDICAL TREATMENT: List ALL doctors seen in a clinic or doctor's office in the last 15 months.

1. Doctor's Name: _____ Clinic Name: _____

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

2. Doctor's Name: _____ Clinic Name: _____

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

3. Doctor's Name: _____ Clinic Name: _____

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

List ALL **hospitals, emergency rooms, or urgent care facilities** the child has visited in the last **15 months**. List the name of facility only; we do not need individual names of doctors.

1. Facility Name: _____ ☐ INPATIENT ☐ OUTPATIENT

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

2. Facility Name: _____ ☐ INPATIENT ☐ OUTPATIENT

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

3. Facility Name: _____ ☐ INPATIENT ☐ OUTPATIENT

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

4. Facility Name: _____ ☐ INPATIENT ☐ OUTPATIENT

   Address: _____ Phone: _____

   _____ Reason for Visit: _____

   _____ Date Last Seen: _____

List ALL **THERAPY PROVIDERS (outside of school setting)** that the child has visited in the last **15 months**. In this section please list all **Occupational Therapy, Physical Therapy, Speech Therapy**, etc. *Please provide complete contact information for each provider*. ***If services are coordinated through BabyNet, it is still necessary that you provide us with the contact information for each individual provider, as we are not always able to obtain records from BabyNet directly.***

1. Provider Name: _____

   Address: _____ Phone: _____

   _____ Type of Provider: _____

   _____ Date Last Seen: _____

2. Provider Name: _____

   Address: _____ Phone: _____

   _____ Type of Provider: _____

   _____ Date Last Seen: _____

3. Provider Name: _____

   Address: _____ Phone: _____

   _____ Type of Provider: _____

   _____ Date Last Seen: _____

4. Provider Name: _____

   Address: _____ Phone: _____

   _____ Type of Provider: _____

   _____ Date Last Seen: _____

5. Provider Name: _____

   Address: _____ Phone: _____

   _____ Type of Provider: _____

   _____ Date Last Seen: _____

List any additional places where you have had tests or imaging (blood work, xrays, CTs, etc) performed in the last 15 months **if facility has not already been listed above**.

1. Facility Name: _____ Date Last Seen: _____

   Address: _____ Phone: _____

   _____ Test/Image: _____

   _____ _____

2. Facility Name: _____ Date Last Seen: _____

   Address: _____ Phone: _____

   _____ Test/Image: _____

   _____ _____

REMARKS

Use this space to provide additional information that may help make a decision on your disability claim.

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

Clear Form

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.html