SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Continuing Disability Report - Child Under Age 19

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

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

☐ *File for last favorable decision not found* ______ *(Initials)* ☐ Child CDR Retro: ___________

Household Number: _______________ Application Date: ___ / ___ / ___
(Filing Date on MAO99)

THIS BOX FOR DHHS USE ONLY

Number of pages received and scanned: _____

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?

____

Any change (better or worse) or new injuries or illnesses since the child began receiving benefits?

☐ Yes ☐ No If yes, what has changed, and when?

____

____

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: ______________________________

4. 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: ______________________________ (Circle all that apply) INPATIENT*OUTPATIENT

   Address: ____________________________________ Phone: ____

   ____ Reason for Visit: ______________________________

   ____ Date Last Seen: ________________________________

2. Facility Name: ______________________________ (Circle all that apply) INPATIENT*OUTPATIENT

   Address: ____________________________________ Phone: ____

   ____ Reason for Visit: ______________________________

   ____ Date Last Seen: ______________________________

3. Facility Name: ______________________________ (Circle all that apply) INPATIENT*OUTPATIENT

   Address: ____________________________________ Phone: ____

   ____ Reason for Visit: ______________________________

   ____ Date Last Seen: ________________________________

4. Facility Name: ______________________________ (Circle all that apply) INPATIENT*OUTPATIENT

   Address: ____________________________________ Phone: ____

   ____ Reason for Visit: ______________________________

   ____ Date Last Seen: ________________________________

5. Facility Name: ______________________________ (Circle all that apply) 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: ______________________

3. Facility Name: ______________________ Date Last Seen: ______________________

   Address: ______________________ Phone: ______________________

   ______________________ Test/Image: ______________________

   ______________________ ______________________

4. 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.

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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