

CHILDREN'S HEALTH INSURANCE PROGRAM

IDENTIFICATION TOOL

For Children with Complex Special Health Care Needs

Child's Name: _____ Health Plan: _____
 Child's Address: _____ PCP: _____
 Child's Phone: _____ Child's ID #: _____

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 <small>(If YES, go to 1A)</small>	NO <small>(If NO, go to 2)</small>
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): <i>(Note: a YES for ANY of the items listed below (a-d) will qualify as a YES response for question 2.)</i>	YES <small>(If YES to any (a-d) listed below go to 2A)</small>	NO <small>(If NO, to all, go to 3)</small>
	a. Medicines prescribed by a doctor other than vitamins		
	b. Mental health treatment or counseling		
	c. Physical, speech, or occupational therapy		
	Special equipment (for example: to help 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 at least 12 months?	YES	NO
3	Does your child currently have these (check all that apply): <i>(Note: a YES for ANY of the items listed below (a-d) will qualify as a YES response for question 2.)</i>	YES <small>(If YES to any (a-d) listed below go to 3A)</small>	NO <small>(If NO, to all, go to 4)</small>
	Life-threatening allergic reactions		
	A special diet prescribed by a doctor		
	A learning or behavioral difficulty for which he or she receives professional treatment or counseling		
	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 need or use more medical care, mental health or education services than usual or routine for most children of the same age?	YES <small>(If YES, go to 4A)</small>	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

ADDITIONAL INFORMATION:

Please provide diagnosis information, if available.

Primary: _____

Secondary: _____