

PARENT/GUARDIAN QUESTIONNAIRE

**Katie Beckett Unit
Center for Child and Family Health
RI Executive Office of Health & Human Services
Hazard Building (Bldg 074) – 74 West Road, Ground Level
Cranston, R.I. 02920
Main Number (401) 462-5300**

Purpose: The requested information is required to assist in the determination or redetermination of Disability and Level of Care (LOC) for a child’s Medical Assistance eligibility through the Katie Beckett Coverage Group.

PLEASE COMPLETE, SIGN, AND RETURN TO THE ABOVE ADDRESS.

For help in completing this form, you may telephone:

- * Department of Human Services (DHS) InfoLine at (401) 462-5300
- * Relay Rhode Island (available 24 hours/day and 7 days/week) 1 (800) 745-6575 or 711
- * DHS InfoLine Telecommunications Device for the Deaf (TTY) (401) 462-3363

Non-English interpreters, American Sign Language (ASL) and alternate formats, including Braille and large print, can be provided at no cost, upon request.

1a. Applicant child’s <u>LAST</u> name:	1b. Applicant child’s <u>FIRST</u> name:	1c. <u>Middle Name</u>
2. Address of applicant child: <i>(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route, City State and Zip):</i>		
3. Applicant child’s Social Security Number:	4. Applicant child’s birthdate: (mm/dd/yyyy)	5. Applicant child’s sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
6a. Parent/Guardian/Adult representative contact for the applicant child: Name: Relationship:	6b. Parent/Guardian/Adult representative Home & Daytime phone numbers: 1 st : (_____) _____ 2 nd : (_____) _____ Email address <i>(if available)</i> : _____ @ _____ Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please indicate your need below:</i> <input type="checkbox"/> Language needed: _____ <input type="checkbox"/> ASL	
7a. Additional Parent/Guardian/Adult representative contact for the applicant child, <i>if applicable</i> : Name: Relationship:	7b. Parent/Guardian/Adult representative Home & Daytime phone numbers: 1 st : (_____) _____ 2 nd : (_____) _____ Email address <i>(if available)</i> : _____ @ _____ Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please indicate your need below:</i> <input type="checkbox"/> Language needed: _____ <input type="checkbox"/> ASL	

APPLICANT CHILD'S NAME: _____ **DATE OF BIRTH:** _____

<p>8. Daily Care Activities: Describe what accommodations/modifications are needed on a daily basis for the applicant child to successfully complete the following daily care activities. Also, please describe any special help or equipment needed.</p> <p>Please <u>circle</u> the correct letter to identify if the child is <u>Independent</u> (I), <u>Needs some help</u> (N), or is <u>Dependent</u> (D) on you or others to complete the below listed activities, and <u>as expected of a child of the same age</u>.</p>	
Bathing:	I N D
Dressing:	I N D
Skin Care:	I N D
Grooming:	I N D
Toileting:	I N D
Eating:	I N D
Sleeping:	I N D
<p>9a. Understanding/Communication: Describe how the child learns and relates to others at home, in school and at play.</p> <p>What special help or equipment does the child need to understand or communicate?</p> <p>How does the child compare to typically developing children of the same age?</p>	
<p>Understanding or responding to immediate family, other children, other adults:</p>	
<p>Communication/ Speech:</p>	
<p>Learning or playing:</p>	
<p>Growth and Development:</p>	
<p>Social Development:</p>	

APPLICANT CHILD'S NAME: _____ **DATE OF BIRTH:** _____

9b. Movement and Mobility: Describe how the applicant child moves around. What special help does the child need to move around, if any? Are there vision or hearing impairments?

Describe child's Fine Motor Function (eating, writing, puzzles):

Gross Motor Function (sitting, walking, running, jumping, riding bike):

Hearing:

Vision:

10. Behavior: Describe how the applicant child shows affection, shares feelings, gets along and cooperates with others:

11. Does the applicant child exhibit any behavior(s) that may be a safety risk to him/herself or others? If yes, what modifications and accommodations are needed to ensure the child's safety?

12a. Therapies: What therapies have been recommended for the applicant child, if any?

- Physical Therapy: How often? _____
- Occupational Therapy: How often? _____
- Speech/Language Therapy: How often? _____
- Behavior Therapy: How often? _____
- Other (please list) _____

12b. Therapies: What therapies does the applicant child receive, if any?

- Physical Therapy: How often? _____
- Occupational Therapy: How often? _____
- Speech/Language Therapy: How often? _____
- Behavior Therapy: How often? _____
- Other (please list) _____

APPLICANT CHILD'S NAME: _____ **DATE OF BIRTH:** _____

13. Medication: List all of the applicant child's current medications and dosages: (Examples: Epi-Pen, Synergist, Botox, Diastat, Digoxin, psychotropic medications)

14a. Home Health Services: (*NEEDED*):

Please check the 'Yes' box if the applicant child is *in need* of any substantial medical or nursing services. Yes No

List needed services: _____

(Examples of needed services: Tube feedings, Central Venous Line, Respiratory Care, Oxygen Administration, Infusions, Home Health Care services, Seizure Activity and Management, Pain Management, Transfusions, Complex Medication Management, Life threatening condition)

Please check any services which have been recommended for the applicant child:

CNA or Home Health Aide Personal Care Worker Skilled Nursing

14b. Home Health Services: (*RECEIVING*):

Please check the 'Yes' box if the applicant child *is receiving* substantial medical or nursing services. Yes No

List services: _____

(Examples: Tube feedings, Central Venous Line, Respiratory Care, Oxygen Administration, Infusions, Home Health Care services, Seizure Activity and Management, Pain Management, Transfusions, Complex Medication Management, Life threatening condition)

Please check below which services the applicant child *is receiving in the home or school*:

CNA or Home Health Aide Personal Care Worker Skilled Nursing

15a. Hospitalizations: List all of the applicant child's hospitalizations in the last 12 months:

Hospital Name	Reason for Admission	Admission Date	Discharge Date
1. _____			
2. _____			
3. _____			

15b. Within the last 12 months, has the applicant child been admitted to or received care at any of the following?
If Yes, please check box and provide explanation:

Residential facility Reason: _____

Out-patient services Reason: _____

Emergency room visits Reason: _____

Other: _____ Reason: _____

APPLICANT CHILD'S NAME: _____ **DATE OF BIRTH:** _____

16a. Early Intervention (Please answer for applicants under 3 years of age):

1. Does the applicant child have an Individualized Family Service Plan (IFSP) and receive Early Intervention services? Yes No

2. Name of Early Intervention Provider: _____

EI Service Coordinator: _____ Phone Number (____) _____

3. Does Early Intervention provide any of the following services to the applicant child?

Speech therapy Yes No

Physical therapy Yes No

Occupational therapy Yes No

16b. Education: (Please answer for applicants 3 years of age and older):

1) Is the applicant child currently enrolled in school? Yes No

If "No," explain why the applicant child is not attending school or is receiving home schooling:

2) What is the applicant child's current grade in school or the highest grade completed? _____

3) List the name of school where the applicant child is currently enrolled:

Name of School _____

School Social Worker: _____ Phone Number (____) _____

a. Does the applicant child presently have a(n) (please check one): IEP 504 Plan

b. Is the applicant child receiving special education? Yes No

c. Does the child receive substantial supports in the school? Yes No

d. Is the applicant child having any major problems in school? Yes No

e. Has the applicant child been tested by the school? Yes No

f. Does school provide any of the following services to the applicant child?

Speech therapy Yes No

Physical therapy Yes No

Occupational therapy Yes No

Counseling Yes No

g. Does the applicant child require special transportation to or from school? Yes No

h. Is the applicant child absent from school more than one day each month? Yes No

APPLICANT CHILD'S NAME: _____ **DATE OF BIRTH:** _____

17. Professionals: List all physicians and specialists who provide services or supports to the applicant child. Start with the physician who knows the child's needs best.

Also, list other important members of the applicant child's team: primary doctor, specialists, school, hospital, or clinical professionals who provide therapies and non-medical service providers/resources, or others that may provide care.

1. Name _____ Specialty _____

Treatment/ Hospital _____ Phone # (____) _____

Address _____ City _____ State _____ Zip _____

2. Name _____ Specialty _____

Treatment/ Hospital _____ Phone # (____) _____

Address _____ City _____ State _____ Zip _____

3. Name _____ Specialty _____

Treatment/ Hospital _____ Phone # (____) _____

Address _____ City _____ State _____ Zip _____

4. Name _____ Specialty _____

Treatment/ Hospital _____ Phone # (____) _____

Address _____ City _____ State _____ Zip _____

5. Name _____ Specialty _____

Treatment/ Hospital _____ Phone # (____) _____

Address _____ City _____ State _____ Zip _____

Previous Services Received through Rhode Island Medical Assistance (Rite Care, Rite Share, Katie Beckett, SSI, Foster Care/Adoption Subsidy)

Please answer all questions that apply to your child and if not involved please answer not applicable:

1. Have you ever been involved with a Cedarr Center? _____

a. Which one? _____

b. How long involved? _____

2. Has your child ever received: (If yes, please list the providers)

a. ABA Therapy _____ Dates of Service: _____

b. HBTS _____ Dates of Service: _____

c. PASS _____ Dates of Service: _____

d. RESPITE _____ Dates of Service: _____

e. KIDS-CONNECT _____ Dates of Service: _____

f. SKILLED NURSING _____ Dates of Service: _____

g. CERTIFIED NA _____ Dates of Service: _____

APPLICANT CHILD'S NAME: _____ **DATE OF BIRTH:** _____

18. You know the applicant child best. Please provide information about the child's condition, needs (*both met and unmet*) that haven't already been described or that you would like to share, and the impact on the family. Describing a "day in the life of the child and family" is a good way to begin.

**(If you need more space or want to write a full summary on separate paper or computer, this is welcome.)*

APPLICANT CHILD'S NAME: _____ **DATE OF BIRTH:** _____

I certify under penalty of perjury that my answers are correct, including information about citizenship and alien status, and complete to the best of my knowledge and belief. I know that under the state of Rhode Island General Laws, Section 40-6-15, a maximum fine of \$1,000, or imprisonment of up to five (5) years, or both, may be imposed for a person who obtains or attempts to obtain, or aids or abets any person to obtain, public assistance to which s/he is not entitled, or who willfully fails to report income, resources or personal circumstances or increases therein which exceed the amount previously reported.

I agree to give the EOHHS accurate information, and I give the EOHHS permission to obtain any appropriate documentation in order to prove my statements.

I understand and agree to notify the EOHHS of any changes within ten (10) days. I understand that under State and Federal law, there is a penalty for making false and misleading statements. I agree to cooperate fully with the State and Federal personnel conducting quality reviews.

I understand that Medical Assistance does not pay medical expenses that a third party is supposed to pay. I agree to provide the EOHHS with my and my spouse's valid Social Security Number(s), upon request, if the child is determined eligible. This information is for Third Party Liability use. I understand that by signing below, I am assigning the child's rights to any third party payment to the EOHHS, including payment for lawsuits, hospital and health insurance policies to cover benefits provided. I also understand that the EOHHS has a potential lien against the child's estate.

I know that the information I have given is confidential and used only for administration of the EOHHS programs. The EOHHS will not release information about me or the applicant child without my written consent except for the administration of the program and as provided in State law and regulations. I know that the child's eligibility will not be affected by race, color, national origin, disability, sex, age, or sexual orientation, except where this is restricted by law. If the EOHHS finds my child ineligible, I may reapply at any time. I know that I have the right to appeal any agency decision or delays, and receive a hearing before a EOHHS Hearing Officer.

Sign, date and submit to the EOHHS Katie Beckett Unit. Completed form must be submitted with original signatures.

SIGNATURE of Applicant Child's Parent/Guardian/Representative

Date Signed

Please PRINT name

Relationship to Applicant Child

Personally identifiable information on this form is used to help determine eligibility for the R.I. Medical Assistance Program (Katie Beckett Coverage Group) and, if eligibility is found, will provide information necessary to receive Medical Assistance. This information will be used only for this purpose.