

South Carolina Department of Health and Human Services

Child Under Age 19 – DISABILITY REPORT

Initial

TEFRA

Retro Only

**Instructions:** This form is used to request a disability determination as an eligibility requirement for Medicaid. *It is the responsibility of the Medicaid Eligibility Worker to ensure that the form is filled out with black or blue ink and that each blank is completed.* A copy of the completed form must be maintained in the case record.

Applicant: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

(Please Print)

Date of Birth: \_\_\_\_\_ Sex:  Male  Female If Deceased, Date of Death: \_\_\_\_\_

Applicant's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Contact Person's Address: \_\_\_\_\_

City State Zip Code

**I. DISABILITY**

a) What is the child's disability? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b) Explain how the child's disability affects his or her ability to function. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c) Have you applied for SSI disability benefits for your child?  Yes  No  
If yes, date of application: \_\_\_\_\_  
Was application made in SC?  Yes  No  
If no, what state? \_\_\_\_\_

d) Have you applied for Social Security disability benefits for your child?  Yes  No  
If denied by SSA, have you asked them to reconsider your claim?  Yes  No  
Did SSA refuse to reconsider your claim?  Yes  No  
Did you request an appeal or a hearing?  Yes  No

- e) Please give the name of anyone we may contact (other than the child's doctor or teacher), such as a neighbor, grandparent, etc., who knows about the child's condition.

Name of Contact \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone (\_\_\_\_\_) \_\_\_\_\_ Relationship to child \_\_\_\_\_

- f) Please give the name of the child's regular pediatrician and his or her complete address and telephone number.

Name \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Date first seen: \_\_\_\_\_ Date last seen: \_\_\_\_\_ Next Appointment \_\_\_\_\_  
Reason for visits: \_\_\_\_\_

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## II. MEDICAL INFORMATION ABOUT THE CHILD'S DISABILITY

**NOTE:** If you need additional space for medical sources, list their names, addresses and reasons for visits in the "Remarks" section on page five or attach a separate piece of paper.

- a) List name, address and telephone number of the doctor who has the child's most recent medical records. (We need a complete address to request medical records.)

Name \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Date first seen: \_\_\_\_\_ Date last seen: \_\_\_\_\_ Next appointment: \_\_\_\_\_  
Reason for visits \_\_\_\_\_  
\_\_\_\_\_

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- b) Has the child been seen by any other doctors since the disability or injury began?  Yes  No

If yes, complete the following. (We need a complete address.)

Name \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Date first seen: \_\_\_\_\_ Date last seen: \_\_\_\_\_ Next appointment: \_\_\_\_\_  
Reason for visits \_\_\_\_\_  
\_\_\_\_\_

- c) Has the child been hospitalized or received emergency room treatment for the illness or injury?  
 Yes  No If yes, complete the following. (We need a complete address.)

Name of Hospital \_\_\_\_\_ Patient Number \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Was the child an in-patient (stayed at least overnight)?  Yes  No

Admission Dates: \_\_\_\_\_

Reason for Hospitalization or Emergency Room Treatment \_\_\_\_\_

\_\_\_\_\_

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- d) Has the child received treatment from a hospital outpatient clinic or other type of clinic?  Yes  No  
If yes, complete the following. (We need a complete address.)

Name of Clinic \_\_\_\_\_ Patient Number \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date(s) of Treatment: \_\_\_\_\_

Reason for Treatment \_\_\_\_\_

\_\_\_\_\_

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- e) Has the child had any special diagnostic outpatient studies (x-rays, blood tests, EKG's, etc.) performed at a hospital or private laboratory/clinic?  Yes  No

If yes, complete the following. (We need a complete address.)

Type of Study/Test \_\_\_\_\_

Name of Hospital, Clinic or Laboratory \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

When were these studies done? \_\_\_\_\_

\_\_\_\_\_

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- f) Is the child seen regularly or has the child ever been tested or evaluated by any of the following agencies? If available, please include copies of any medical, psychological, developmental information/assessments (including service plans) from these agencies.

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|--|------------------------------|-----------------------------|
| 1. S.C. Health Department Clinic (DHEC)    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Division of Children's Health              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Children's Rehabilitative Services (CRS)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Women, Infant and Children's Program (WIC) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Baby Net                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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|--|------------------------------|-----------------------------|
| 2. Department of Disabilities and Special Needs (DDSN) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| County DDSN Board/Regional Center                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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|---|------------------------------|-----------------------------|
| 3. South Carolina Department of Mental Health | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mental Health Center                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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|---|------------------------------|-----------------------------|
| 4. Continuum of Care for Emotionally Disturbed Children | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|------------------------------|-----------------------------|

5. Speech and Hearing Center  Yes  No
6. Other (i.e., physical, occupational therapy, etc.)  Yes  No  
 If yes, specify: \_\_\_\_\_

**For each of the agencies at which the child has been seen, complete the following.  
 If you have a copy of the child's service plan, please attach.**

Name of Facility \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Date first seen: \_\_\_\_\_ Date last seen: \_\_\_\_\_ Next appointment: \_\_\_\_\_  
 Type of Treatment or Evaluation Received \_\_\_\_\_  
 Case Manager \_\_\_\_\_ Telephone ( \_\_\_\_\_ ) \_\_\_\_\_

Name of Facility \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Date first seen: \_\_\_\_\_ Date last seen: \_\_\_\_\_ Next appointment: \_\_\_\_\_  
 Type of Treatment or Evaluation Received \_\_\_\_\_  
 Case Manager \_\_\_\_\_ Telephone ( \_\_\_\_\_ ) \_\_\_\_\_

**III. SCHOOL INFORMATION**

- a) Is the child currently attending school?  Yes  No  
 If yes, complete the following.

Current Grade \_\_\_\_\_ Teacher \_\_\_\_\_  
 Name of School \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

- b) Is the child in a special education program?  Yes  No  
 If yes, explain the services provided (i.e., speech, learning disabled, etc.) \_\_\_\_\_

Special Education Teacher's name: \_\_\_\_\_

Do you have a copy of the child's Individual Education Plan (IEP) report?  Yes  No  
 If yes, please attach a copy.

- c) Does the child attend any type of preschool, daycare or after school program?  Yes  No  
 If yes, please complete the following.

Name of School \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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**IV. DAILY ACTIVITIES**

Describe what the child does in a typical day. Include any participation in school, church or community activities.

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**V. REMARKS**

Use this section to answer any previous questions and to add additional information that you think will be helpful in making a decision in your child's disability claim.

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**I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE.**

**Print Name of Applicant/Representative** \_\_\_\_\_

**Applicant/Representative Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Relationship** \_\_\_\_\_

**FOR DHHS USE ONLY**

Application Date: _____	Category of Application: _____
Retro Month(s) Requested: _____	
Worker County: _____	
Medicaid Eligibility Worker: _____	Telephone: (_____) _____
Worker's Supervisor: _____	Fax Number: (_____) _____
	Telephone: (_____) _____