

CERTIFICATION FOR DISABLED CHILDREN LIVING AT HOME

1. Child's Name (Last) (First) (MI) (Legal Name) _____	2. Sex <input type="checkbox"/> M <input type="checkbox"/> F	3. Date of Birth _____	4. SSN # _____ Medicaid # _____																				
5. Child's Address: Street or Route _____ City _____ State _____ Zip _____ Telephone Number _____	6. Physician's Name _____ Address _____ Telephone Number _____																						
7. Please indicate in the following areas, the child's needs and problems: <table style="width:100%; border: none;"> <tr> <td style="width:33%; vertical-align: top;"> Behavior Adjustments: a) <input type="checkbox"/> Anxious b) <input type="checkbox"/> Agitated c) <input type="checkbox"/> Confused d) <input type="checkbox"/> Depressed e) <input type="checkbox"/> Hostile </td> <td style="width:33%; vertical-align: top;"> f) <input type="checkbox"/> Disoriented g) <input type="checkbox"/> Retarded h) <input type="checkbox"/> Hallucinates i) <input type="checkbox"/> Other: _____ </td> <td style="width:33%; vertical-align: top;"> Sensory: a) <input type="checkbox"/> Seizures b) <input type="checkbox"/> Comatose c) <input type="checkbox"/> Semi-comatose d) <input type="checkbox"/> Lethargic e) <input type="checkbox"/> Weak </td> </tr> <tr> <td style="vertical-align: top;"> Limitations: a) <input type="checkbox"/> Transferring assistance b) <input type="checkbox"/> Assisted ambulation c) <input type="checkbox"/> Braces d) <input type="checkbox"/> Wheelchair e) <input type="checkbox"/> Assisted dressing f) <input type="checkbox"/> Total care required g) <input type="checkbox"/> Other: _____ </td> <td style="vertical-align: top;"> Elimination: a) <input type="checkbox"/> Bladder <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter b) <input type="checkbox"/> Bowel <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy <input type="checkbox"/> Other: _____ </td> <td style="vertical-align: top;"> Diet: <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Gastrostomy tube <input type="checkbox"/> Must be fed <input type="checkbox"/> Other: _____ </td> </tr> </table>				Behavior Adjustments: a) <input type="checkbox"/> Anxious b) <input type="checkbox"/> Agitated c) <input type="checkbox"/> Confused d) <input type="checkbox"/> Depressed e) <input type="checkbox"/> Hostile	f) <input type="checkbox"/> Disoriented g) <input type="checkbox"/> Retarded h) <input type="checkbox"/> Hallucinates i) <input type="checkbox"/> Other: _____	Sensory: a) <input type="checkbox"/> Seizures b) <input type="checkbox"/> Comatose c) <input type="checkbox"/> Semi-comatose d) <input type="checkbox"/> Lethargic e) <input type="checkbox"/> Weak	Limitations: a) <input type="checkbox"/> Transferring assistance b) <input type="checkbox"/> Assisted ambulation c) <input type="checkbox"/> Braces d) <input type="checkbox"/> Wheelchair e) <input type="checkbox"/> Assisted dressing f) <input type="checkbox"/> Total care required g) <input type="checkbox"/> Other: _____	Elimination: a) <input type="checkbox"/> Bladder <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter b) <input type="checkbox"/> Bowel <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy <input type="checkbox"/> Other: _____	Diet: <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Gastrostomy tube <input type="checkbox"/> Must be fed <input type="checkbox"/> Other: _____														
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8. You must attach copies of the following: a) History and physical exam completed within a year of application and signed by the physician; b) Disabled Child Questionnaire; c) Psychological evaluation if behavior problems exist; d) Additional information which would substantiate why your child would require care rendered in a medical facility.																							
9. List all the child's current medical problems and physical limitations and or restrictions including any special care given: _____ _____ Name all physicians involved in treating the child's condition: _____ _____ Please list all hospitalizations including name of facility, dates and reason for admission: _____ _____																							
10. <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width:35%;">Current Medications:</th> <th style="width:15%;">Dosage:</th> <th style="width:15%;">Frequency:</th> <th style="width:35%;">Treatments: (IV, Respiratory)</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>				Current Medications:	Dosage:	Frequency:	Treatments: (IV, Respiratory)																
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11. This is to authorize the facility or attending physician to provide the Mississippi Medicaid Agency with medical information necessary to determine if the individual meets the requirements for eligibility. Signed: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 20px;"> Responsible Party Relationship to Child Date </div> <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 20px; margin-top: 5px;"> Address (if different from above) Telephone Number </div>																							
TO BE COMPLETED BY PHYSICIAN																							
12. Diagnosis: a) Primary _____ b) Secondary _____ c) Prognosis _____ d) Significant Problems _____ I certify that this child requires the level of care provided by a hospital, nursing facility, or an Intermediate Care Facility for the Mentally Retarded. <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 20px;"> Physician's Signature Date </div>																							

MEDICAID STAFF USE ONLY

Approved () Disapproved ()

Signature of Reviewer

Title REGIONAL OFFICE COPY

Date