Initial
Recertification { }

CERTIFICATION FOR DISABLED CHILDREN LIVING AT HOME

1. Child's Name (Legal Name) (Last) (First) (MI)
2. Sex ( ) M ( ) 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:

Behavior Adjustments:
a) ☐ Anxious
b) ☐ Agitated
c) ☐ Confused
d) ☐ Depressed
e) ☐ Hostile
f) ☐ Disoriented
g) ☐ Retarded
h) ☐ Hallucinates
i) ☐ Other: _____

Sensory:
a) ☐ Seizures
b) ☐ Comatose
c) ☐ Semi-comatose
d) ☐ Lethargic
e) ☐ Weak
f) ☐ Vision impaired
g) ☐ Hearing impaired
h) ☐ Communication problem
i) ☐ Other: _____

Limitations:
a) ☐ Transferring assistance
b) ☐ Assisted ambulation
c) ☐ Braces
d) ☐ Wheelchair
e) ☐ Assisted dressing
f) ☐ Total care required
g) ☐ Other: _____

Elimination:
a) Bladder
☐ Incontinent
☐ Catheter
b) Bowel
☐ Incontinent
☐ Colostomy
☐ Other: _____

Diet:
☐ Nasogastric tube
☐ Gastrostomy tube
☐ Must be fed
☐ Other: _____

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.

Current Medications:	Dosage:	Frequency:	Treatments: (IV, Respiratory)

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: _____
Responsible Party Relationship to Child Date

_____
Address (if different from above) Telephone Number

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.

_____
Physician's Signature Date

MEDICAID STAFF USE ONLY Approved ( ) Disapproved ( )

_____
Signature of Reviewer Title Date

INSTRUCTION SHEET
CERTIFICATE FOR DISABLED CHILDREN LIVING T HOME

Medicaid for disabled children living at home is a special eligibility coverage group for certain disabled children age 18 and under who are cared for at home. These disabled children must require extensive medical care, equivalent to care received in a hospital, nursing facility, or an Intermediate Care Facility for the Mentally Retarded. This means the child must require health related or rehabilitative services on a continuous and ongoing daily basis and that it is appropriate to provide this care to the child at home.

WHO IS NOT ELIGIBLE?

- **Children with acute, short term problems which do not result in long term impairment, i.e., ear infections, sore throats, and tonsillitis, measles, mumps, etc. which have an anticipated recovery period.**
- **Children with diseases or disorders that have become stabilized, i.e., diabetes, asthma, seizures, etc.**
- **Children without physical complications or functional limitations which require the same care as other children their same age, such as Down's Syndrome, and learning disorders.**

INSTRUCTIONS

This form must be completed in its entirety. Please note "N/A" when appropriate and attach additional pages if more space is needed. If the form is incomplete or the history and physical exam and Disabled Child Questionnaire is not attached, the form will be disapproved and returned. A reevaluation will be made when this information is resubmitted.

Questions #1-11	**This section must be completed by the responsible party or care giver.**
Question # 9	**Describe in detail, assistance given by the care giver.**
Question # 12	**This section must be completed, signed, and dated by the physician. The physician's certification does not determine whether the child should be placed in a hospital, nursing facility or an Intermediate Care Facility for the Mentally Retarded, but whether the child requires the extensive care provided by these facilities.**