Rhode Island Department of Human Services

Long Term Services & Supports | Katie Beckett

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PARENT/GUARDIAN QUESTIONNAIRE

Purpose: **To assist in the determination or redetermination of disability and level of care (LOC) for a child's Medicaid eligibility through the Katie Beckett Coverage Group.**

PLEASE COMPLETE, SIGN, AND RETURN TO THE ABOVE ADDRESS.
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 last name:	1b. Applicant child's first name:	1c. Middle Name
2. Address (Number, Street, Apt. No. (if any), P.O. Box, or Rural Route, City State and Zip):		
3. Child's Social Security Number:	4. Child's birthdate (mm/dd/year):	5. Child's sex: ☐ Male ☐ Female
6a. Parent/Guardian/Adult representative contact for the child: Name: ____________________ Relationship: ____________________	6b. Parent/Guardian/Adult representative home & daytime phone numbers: 1st: (_______) ____________ 2nd: (_______) ______________ Email address (*if available*): ____________@______________________ Interpreter Needed? ☐Yes ☐ No *If Yes, please indicate your need below:* ☐ Language needed: ____________________ ☐ ASL	
7a. Additional Parent/Guardian/Adult representative contact for the child, *if applicable*: Name: ____________________ Relationship: ____________________	7b. Parent/Guardian/Adult representative Home & Daytime phone numbers: 1st: (_______) ____________ 2nd: (_______) ______________ Email address (*if available*): ____________@______________________ Interpreter Needed? ☐Yes ☐ No *If Yes, please indicate your need below:* ☐ Language needed: ____________________ ☐ ASL	

8. Daily Care Activities - Describe what accommodations/modifications are needed on a daily basis for the child to successfully complete the following daily care activities. Also, please describe any special help or equipment needed.

Please circle the correct letter to identify if the child is Independent (I), Needs some help (N), or is Dependent (D) on you
or others to complete the below listed activities, and as expected of a child of the same age.

Activity	
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

9a. Understanding/Communication - Describe how the child learns and relates to others at home, in school and at play.
What special help or equipment does the child need to understand or communicate?
How does the child compare to typically developing children of the same age?

Understanding or responding to immediate family, other children, other adults:

Communication/ Speech:

Learning or playing:

Growth and Development:

Social Development:

9b. Movement and Mobility - Describe how the 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 child shows affection, shares feelings, gets along and cooperates with others:

11. Does the 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 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 child receive, if any?

□ Physical Therapy: How often? ____________________
□ Occupational Therapy: How often? ____________________
□ Speech/Language Therapy: How often? ____________________
□ Behavior Therapy: How often? ____________________
□ Other (please list) ____

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

14a. Home Health Services *(NEEDED)* - Check the 'Yes' box if the 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 child:
□ CNA or Home Health Aide □ Personal Care Worker □ Skilled Nursing

14b. Home Health Services *(RECEIVING* - Check the 'Yes' box if the 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 child *is receiving* in the home or school:
□ CNA or Home Health Aide □ Personal Care Worker □ Skilled Nursing

15a. Hospitalizations - List all of the 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 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: ____

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

1. Does the 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 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 child currently enrolled in school? □ Yes □ No

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

____

____

____

2. What is the child's current grade or the highest grade completed? ______________________
3. Name of school where the child is currently enrolled: ____________________________________
   School Social Worker: ________________________________ Phone Number (_____) ______________________
   a. Does the child presently have a(n) (please check one): □ IEP □ 504 Plan
   b. Is the child receiving special education? □ Yes □ No
   c. Does the child receive substantial supports in the school? □ Yes □ No
   d. Is the child having any major problems in school? □ Yes □ No
   e. Has the child been tested by the school? □ Yes □ No
   f. Does school provide any of the following services to the child?
      - Speech therapy □ Yes □ No
      - Physical therapy □ Yes □ No
      - Occupational therapy □ Yes □ No
      - Counseling □ Yes □ No
   g. Does the child require special transportation to or from school? □ Yes □ No
   h. Is the child absent from school more than one day each month? □ Yes □ No

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

Also, list other important members of the 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 Medicaid (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 Cedar 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: _______________

18. You know your 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, please add and additional page.)*

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 RI Department of Human Services (DHS) accurate information, and I give the DHS permission to obtain any appropriate documentation in order to prove my statements.

I understand and agree to notify the DHS 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 Medicaid does not pay medical expenses that a third party is supposed to pay. I agree to provide the DHS 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 DHS, including payment for lawsuits, hospital and health insurance policies to cover benefits provided. I also understand that the DHS 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 DHS programs. The DHS 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 DHS 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 an DHS Hearing Officer.

Sign, date and submit to the address on the first page. 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. Medicaid Program (Katie Beckett Coverage Group) and, if eligibility is found, will provide information necessary to receive Medicaid. This information will be used only for this purpose.