# Physician Certification for Child with Special Needs

| Name of Child | Child's Date of Birth<br>___/___/_____ |
|---|---|

**The above named individual has been identified as a child with special needs.**

**In Pennsylvania a child with a permanent or temporary disability may be eligible for Medical Assistance.**

**The definition of disability in a child under 18 is:**
**A medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.**

## Section I - Disability Verification

**Please verify the child's level of disability below. (Check Only One)**

**1. ____ PERMANENTLY DISABLED - Has a physical or mental disability which results in permanent marked and severe functional limitations. The patient may be a candidate for SSI benefits.**

**2. ____ TEMPORARILY DISABLED - 12 MONTHS OR MORE - Is currently disabled due to a temporary condition as a result of an injury or an acute condition**
**The temporary disability began and is expected to last until_____ .**
**The patient may be a candidate for SSI benefits.**

**3. ____ TEMPORARILY DISABLED – LESS THAN 12 MONTHS - Is currently disabled due to a temporary condition as a result of an injury or an acute condition**
**The temporary disability began and is expected to last until _____ .**

**4. ____ NOT DISABLED -The patient's physical and/or mental condition is such that he or she does not have an impairment that results in marked and severe functional limitations.**

**BOTH OF THE FOLLOWING SECTIONS MUST BE COMPLETED IF #1 OR #2 ABOVE IS CHECKED**

## Section II - Assessment Information

**ASSESSMENT BASED UPON: (Check all that apply)**
**A. ____ PHYSICAL EXAMINATION**
**B. ____ REVIEW OF MEDICAL RECORDS**
**C. ____ CLINICAL HISTORY**
**D. ____ APPROPRIATE TESTS AND DIAGNOSTIC PROCEDURES**
**E. ____ OTHER (Specify) _____**

## Section III - Examination Results

**DATE OF DIAGNOSIS: _____**
**DIAGNOSIS(Primary and Secondary):**
**PRIMARY: _____**

**SECONDARY: _____**

**FUNCTIONAL LIMITATIONS: _____**
**_____**

## Section IV - Signature

**AS A LICENSED MEDICAL PROVIDER, I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY PROFESSIONAL KNOWLEDGE. I FURTHER CERTIFY THAT MY DIAGNOSIS AND ASSESSMENT ARE BASED SOLELY ON THE PATIENT'S CONDITION AS DETERMINED BY MY EXAMINATION. I UNDERSTAND AND AGREE THAT MY DIAGNOSIS AND SUPPORTING DOCUMENTATION MAY BE SUBJECT TO REVIEW BY THE DEPARTMENT OF PUBLIC WELFARE.**

| _____<br>Physician (Print Name) | _____<br>Medical Assistance Provider No. (Optional) |
|---|---|
| _____<br>Physician's Signature | _____ _____<br>Phone No: Date: |

# Physician Certification for Child with Special Needs Instructions

## General instructions

The information on this form and any attachments must be complete and legible. The inability to read this material will require the form be returned to your office and will delay the application process.

## Section I DISABILITY VERIFICATION

1. Choose only **one (1)** level of disability
2. If indicated, enter the date the disability is expected to end.

## Section II ASSESSMENT INFORMATION

1. This assessment must be completed by a psychologist, physician or medical professional under the physician's supervision and authority, e.g. physician assistant, or certified nurse practitioner. Information from a chiropractor is not acceptable documentation.
2. Check all assessment tools that apply.

## Section III EXAMINATION RESULTS

1. Include the date of diagnosis
2. Include the name of each diagnosis and include the ICD_9 code and the description.
3. Be specific and include functional limitations and their impact.
4. Documentation sufficient to support your decision must be available for further review **if required**.

## Section IV SIGNATURE

1. Only the individual who performed the assessment may sign this form
2. The signature must be original or the form will be invalidated
3. Signature or clinic stamps, labels and other facsimilies **are not** acceptable