pennsylvania
DEPARTMENT OF HUMAN SERVICES

Physician Certification for Child with Special Needs

شهادة طبيب لطفل ذي احتياجات خاصة

CAO NAME & ADDRESS

GENERAL INSTRUCTIONS

The information on this form and any attachments must be complete and readable. Any forms we receive that are unreadable will require the form be returned to your office and will delay the application process.

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.

Your office may be required to provide current Objective Medical Documentation (medical or psychological records) from within the past 12 months.

تعليمات عامة

يجب أن تكون المعلومات الواردة في هذا النموذج وأية مرفقات كاملة ومقروءة. أية نماذج نتلقاها وتكون غير مقروءة ستستدعي إعادة النموذج إلى مكتبك وستؤدي إلى تأخير العمل على الطلب.

يجب إكمال هذا التقييم من قبل طبيب نفساني أو طبيب أو مهني طبي تحت إشراف الطبيب وسلطته، مثل مساعد طبيب أو ممرض ممارس معتمد. المعلومات المقدمة من مقوم عظام ليست وثائق مقبولة.

قد يُطلب من مكتبك تقديم مستندات طبية موضوعية حديثة (سجلات طبية أو نفسية) صادرة خلال الـ 12 شهرًا الماضية.

SECTION I – DISABILITY VERIFICATION

1. Choose only **one (1)** level of disability.
2. If the client is temporarily disabled, enter the date the disability began and is expected to end.

SECTION II – ASSESSMENT INFORMATION

Check all assessment tools that apply.

SECTION III – EXAMINATION RESULTS

1. Include the date of diagnosis.
2. Include the name of each diagnosis, the ICD-10 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.

SECTION IV – SIGNATURE

1. Only the individual who performed the assessment may sign this form.
2. Signature or clinic stamps, labels, or other facsimiles **are** acceptable.

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NAME OF CHILD		CHILD'S DATE OF BIRTH _____ / _____ / _____
COUNTY	RECORD NUMBER	SOCIAL SECURITY NUMBER

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.

تم اعتبار الشخص المذكور أعلاه طفلًا ذا احتياجات خاصة. في ولاية بنسلفانيا، قد يكون الطفل المصاب بإعاقة دائمة أو مؤقتة مؤهلاً للحصول على معونة طبية.

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."

Functional limitations include, but are not limited to: the child's ability to sit, stand, walk, push, pull, bend, squat, or climb and/or the child's ability to understand, remember and apply information, concentrate and remain on task, engage appropriately with others, and adapt and conduct oneself appropriately to changes in environmental and/or internal stimuli.

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 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 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:	PRIMARY DIAGNOSIS:	SECONDARY DIAGNOSIS:
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 Human Services.

PSYCHOLOGIST, PHYSICIAN, OR MEDICAL PROFESSIONAL (PRINT NAME):	MEDICAL ASSISTANCE PROVIDER NUMBER (OPTIONAL):	
PSYCHOLOGIST, PHYSICIAN, OR MEDICAL PROFESSIONAL SIGNATURE:	PHONE NUMBER:	DATE: