



## CMS CLINICAL ELIGIBILITY SCREENING FORM

### DEMOGRAPHIC INFORMATION

Interpreter Services Needed (Language Preference or Hearing Impaired):

<b>Screening Conducted:</b> By telephone <input type="checkbox"/> In person <input type="checkbox"/> Other <input type="checkbox"/> _____		<b>Referral Source:</b> _____
		<b>Date Referred:</b> _____
Child's full name (Last, First, MI)	<b>Race:</b> ___ <b>Sex:</b> F <input type="checkbox"/> M <input type="checkbox"/>	
Social Security Number:	Date of Birth:	
Name of Person Answering Questions:	Relationship to child:	
Child's Mailing Address:		
Child's Physical Address:		
Parent/Legal Guardian E-mail Address:		
Home Phone:	Work Phone:	Cell Phone:

**To the best of your knowledge, based on information received from a health care provider, does your child have a condition which is both chronic (meaning expected to last 12 or more months) and is a serious, physical developmental, behavioral, or emotional condition which requires health care and related services of a type of amount beyond that which is generally required by children?**

**Yes – Parent believes child has a special health care need—GO TO QUESTION 1**

**No – End of intake screening—FOLLOW INSTRUCTION IMMEDIATELY BELOW**

- YES – Continue to Question 1**       **NO – End Screening**



## LEVEL I SCREENING

The next questions are about any kind of health problems, concerns, or conditions that may affect your child's physical health, behavior, learning, growth, or physical development. Some of these health problems may affect your child's abilities and activities at school or play. Some of these problems affect the kind or amount of services your child may need or use.

1. Does your child currently need or use **medicine prescribed by a doctor** (other than vitamins)?

\_\_\_\_\_ Yes – Go to Question 1a

\_\_\_\_\_ No – Go to Question 2

- 1a. Is this because of ANY medical, behavioral, or other health condition?

\_\_\_\_\_ Yes – Go to Question 1b

\_\_\_\_\_ No – Go to Question 2

- 1b. Is this a condition that has lasted or is expected to last for at least 12 months?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

- 1c. What is the condition or diagnosis? \_\_\_\_\_

2. Does your child need or use more **medical care, mental health, or education services** than is usual for most children of the same age?

\_\_\_\_\_ Yes – Go to Question 2a

\_\_\_\_\_ No – Go to Question 3

- 2a. Is this because of ANY medical, behavioral, or other health condition?

\_\_\_\_\_ Yes – Go to Question 2b

\_\_\_\_\_ No – Go to Question 3

- 2b. Is this a condition that has lasted or is expected to last for at least 12 months?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

- 2c. What is the condition or diagnosis? \_\_\_\_\_

3. Is your child **limited or prevented** in any way in his or her ability to do the things most children of the same age can do?

\_\_\_\_\_ Yes – Go to Question 3a

\_\_\_\_\_ No – Go to Question 4

- 3a. Is this because of ANY medical, behavioral, or other health condition?

\_\_\_\_\_ Yes – Go to Question 3b

\_\_\_\_\_ No – Go to Question 4

- 3b. Is this a condition that has lasted or is expected to last for at least 12 months?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

- 3c. What is the condition or diagnosis? \_\_\_\_\_



4. Does your child need or get **special therapy**, such as physical, occupational, or speech therapy?

\_\_\_\_\_ Yes – Go to Question 4a

\_\_\_\_\_ No – Go to Question 5

4a. Is this because of ANY medical, behavioral, or other health condition?

\_\_\_\_\_ Yes – Go to Question 4b

\_\_\_\_\_ No – Go to Question 5

4b. Is this a condition that has lasted or is expected to last for at least 12 months?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

4c. What is the condition or diagnosis? \_\_\_\_\_

5. Does your child have any kind of emotional, developmental, or behavioral problem for which he or she needs to get **treatment or counseling**?

\_\_\_\_\_ Yes – Go to Question 5a

\_\_\_\_\_ No

5a. Has this problem lasted or is it expected to last for at least 12 months?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

5b. What is the condition or diagnosis? \_\_\_\_\_

- Child is eligible if all parts of question 3 and all parts of any other question is yes
- Child needs Level II Screening if all parts of question 3 only were answered yes, if the child answered yes to three of the five questions as yes, however, does not meet criteria outlined in the above bullet, or if the child has four or more diagnoses.

**CMS ELIGIBLE?**      **YES**       **NO**       **Needs Level II**

**Completed by:** \_\_\_\_\_

**Date:** \_\_\_\_\_



## **LEVEL II SCREENING**

For those children that screen YES in the *functional limitations* health domain, but answer NO to all other questions, an additional question should be asked to assess if the reason is due to an unmet need.

1. You report that your child is limited or prevented in some way, yet you do not report that your child is utilizing any services for their condition(s). Does your child currently need medications or services for your child that you are unable to obtain?

\_\_\_\_\_ Yes – Let's review your questions to determine what those needs are (go back through questions)  
\_\_\_\_\_ No – End screening

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For those children that answer yes to three questions, but one of those questions is not number 3 (assessing functional limitations), an additional question should be asked to assess if the child is experiencing increased admissions due to the reported condition(s).

1. In the last 12 months, how many times has your child been hospitalized or admitted to a behavioral health/mental facility for the condition(s) you have mentioned?

\_\_\_\_\_ 0 – Go to question 2  
\_\_\_\_\_ 1+ (if one or more admissions, the child should be screened as clinically eligible for CMS)

2. In the last 12 months, how many times has your child been seen in the emergency department for the condition(s) you have mentioned?

\_\_\_\_\_ 0, 1, 2 – End screening  
\_\_\_\_\_ 3+ (if three or more visits, the child should be screened as clinically eligible for CMS)

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For those children not initially clinically eligible for CMSN, but who report health consequences related to at least 4 diagnoses, an additional question should be asked to assess if the child is experiencing increased admissions due to the reported conditions.

1. In the last 12 months, how many times has your child been hospitalized or admitted to a behavioral health/mental facility for the condition(s) you have mentioned?

\_\_\_\_\_ 0 – Go to question 2  
\_\_\_\_\_ 1+ (if one or more admissions, the child should be screened as clinically eligible for CMS)

2. In the last 12 months, how many times has your child been seen in the emergency department for the condition(s) you have mentioned?

\_\_\_\_\_ 0, 1, 2 – End screening  
\_\_\_\_\_ 3+ (if three or more visits, the child should be screened as clinically eligible for CMS)

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