



CMS CLINICAL ELIGIBILITY SCREENING FORM

DEMOGRAPHIC INFORMATION

Interpreter Services Needed (Language Preference or Hearing Impaired):

Screening Conducted: By telephone <input type="checkbox"/> In person <input type="checkbox"/> Other <input type="checkbox"/> _____		Referral Source: _____
		Date Referred: _____
Child's full name (Last, First, MI)		Race: ___ Sex: 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 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

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)

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)
