_____
Date

Dear_____
(Parent/Guardian)

Federal law requires that North Carolina identify children with special health care needs. The purpose of the questionnaire on back of this form is to identify these children. Please read questions 1-5 and answer all the questions. If you answer yes to any two questions in any of the boxes, write the name(s) of the child(ren) on the spaces provided. Sign and date the questionnaire. Return the form to the Department of Social Services by mail or in person. If you have questions about this form, call your worker or the department of social services.

_____
Worker

_____
Telephone number

SPECIAL HEALTH CARE NEEDS QUESTIONNAIRE

Please answer the questions below and return this form to the department of social services.

Parent/Guardian *(Please print)*_____

For office use only

Date_____Due Date_____Co. Case No._____Worker_____

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

1a *Does your child(ren) need this medicine because of ANY medical, behavioral or other health condition that has lasted or is expected to last at least 12 months_____yes_____no.*

*If you answered yes, name the child(ren)*_____
_____

2 *Does your child(ren) need more medical care, mental health or educational services than usual or routine for most children of the same age? yes_____no_____.*

2a *Does your child(ren) need these services because of ANY medical, behavioral or health condition that has lasted or is expected to last at least 12 months?_____yes_____no.*

*If you answered yes, name the child(ren)*_____
_____

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

3a *Is this because of ANY medical, behavioral or other health condition that has lasted or is expected to last at least 12 months? _____yes_____no.*

*If you answered yes, name the child(ren)*_____
_____

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

4a *Does your child need this therapy because of ANY medical, behavioral or other health condition that has lasted or is expected to last at least 12 months?_____yes_____no.*

*If you answered yes,name of the child(ren)*_____
_____

5 *Does your child(ren) currently have any kind of emotional, developmental or behavioral difficulty for which he or she needs treatment or counseling? _____yes_____no.*

5a *Does your child need this treatment or counseling because of ANY medical, behavioral or other health condition that has lasted or is expected to last at least 12 months? _____yes_____no.*

*If you answered yes, name the child(ren)*_____
_____

*Signature*_____ *Date*_____
Parent/Guardian

DMA-5069 (11/00)

(back)