Disability Report for Children

FILLING OUT THIS REPORT

If you need help completing any part of this form, contact your Department of Human Services office. Ask your income maintenance worker to help you.

The information that you give us on this form will be used by the office that makes the disability decision on the child's claim. You can help them by completing as much of the form as you can.

- Please fill out this form before your interview appointment.
- Print or type.
- If your appointment is for an interview by telephone, have this form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you.
- When we ask for certain numbers, such as dates and telephone numbers, we provide spaces to fill in. Please complete all spaces.
- Be sure to explain an answer if an explanation is requested or needed.
- If more space is needed to answer any of the questions, please use the "REMARKS" section and show the number of the question being answered.

If you already have any of the child's medical records at home, please send them to our office with your completed forms or bring them with you to your interview. If you need the records back, tell us and we will photocopy them and return them to you.

You do not need to ask the child's doctors or hospitals for any reports that you do not already have. With your permission, we will do that for you. The information we ask for on this form tells us from whom to request medical and other records. If you cannot remember the names and addresses of any of the child's doctors or hospitals, or the dates of treatment, try to get this information from the telephone book, or from the child's medical bills or prescriptions.

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Iowa Department of Human Services

Disability Report for Children

Sec	tion 1. Identifying Information						
A.	Print Name of Child (first, last, middle ini	itial)			B. Socia	l Security	Number
C.	Show Any Other Names Child Has Used						
0.	Show They O thet T turnes only They obed						
D.	Your Name (if representing an agency, pre-	ovide age	ency name)			
E.	Your Mailing Address (Apt. No., Rural Route, or P.O. Box, if any)		City			State	Zip Code
F.	Daytime telephone number where you ca telephone number where a message can be		•		·	•	•
G.	Your relationship to child						
H.	Can you speak and understand English?		les 🗖	No If no ,	what langua	ge do you	speak?
	Can you read and understand English?		les 🗅	No			
I.	Does the child live with you?		les (Got	aL) [□ No (Cor	ntinue to	nort question)
1.						innue to	next question.)
1.	If the child does not live with you who, do						next question.)
Nam	If the child does not live with you who, do						onship to Child
Nam	If the child does not live with you who, do						
Nam	If the child does not live with you who, do ne ress Number and Street	bes child	live with?	No If no,		on's Relati State ge does th	onship to Child Zip Code
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Sec	tion 2. The Child's Illnesses or Injuries
A.	What are the child's disabling illnesses or injuries ?
B.	When did the child become disabled? Month Day Year
C.	Does the child have any pain related to the child's illnesses or injuries? Yes No
Sec	tion 3. Medical Assistance
Doe	s the child have a medical assistance card ? (for example: Medicaid) Ves No
If Y	es, enter the medical assistance number here
Sec	tion 4. The Child's Medical Treatment
A.	Has the child ever been seen by a health care professional (for example: a doctor, psychologist, or therapist) for the child's illnesses or injuries? \Box Yes \Box No
В.	Since the child became disabled has the child been seen by a health care professional for a mental illness ? Yes No
	If Yes, be sure to include this health care professional in your answers in Section 5.
	If you answered No to questions A. and B. above, skip all of Section 5 and go on to Section 6.

Section 5. Medical Sources

Please tell us who may have medical records or other information about the child's illnesses or injuries. Include doctors, hospitals, clinics, and any other people or organizations (like social services, Vocational Rehabilitation, attorneys). Also include any sources the child will be seeing in the future.

List each source separately. This form has room for six sources. If you have more than six, list the others in **Section 9. Remarks**. After you have listed all the sources, go to Section 6 on page 9.

START WITH THE SOURCE WHO KNOWS THE MOST ABOUT THE CHILD'S ILLNESSES OR INJURIES.

A. FIRST SOURCE

Is this source as	Doctor	Hospital	or Clinic	Agency	Other		
N CO						(Specify)	
Name of Source	3		Address	(Number and Street	, Apt. No. (if an	y), P.O. Box or Rural R	loute)
City				State		Zip Code	
Patient/Clinic/II	D/Claim Number	(if known)	Name of	Counselor/Casew	orker/Therapis	t (if any)	
Telephone Num	ber		Please sh	ow the date of the	child's next a	ppointment (if any)	
)			Month	Day		Year	
If this source is a	a doctor, agency	, or other, con	•	information in the			
Date first seen:				Date last seen	:		
		Day	Year		Month	Day Y	lear
Frequency of V	isits:						
□ Weekly □	Every two wee	ks 🛛 Month	nly 🗖 E	very two months	Quarterly	Less frequently	y
Medical Specia	lty (if doctor)						
f this source is a	a HOSPITAL O	PR CLINIC , w	as the child	d:			
-	t? (stayed at lea enter the beginni		dates.			ne the same day) s first and last seen be	elow.
Beginning Date	-	0 0		First Seen:			
Month	Day	Year		Month	Day	Year	
Ending Date:				Last Seen:			
Month	Day	Year		Month	Day	Year	
Department: _				Department:			
				Show dates of a	any emergency	y room visits:	
				Month	Day	Year	
				Month	Day	Year	
If source is DO	CTOR. HOSPI7	TAL or CLINI	C. for wh	at illnesses or in	iuries was the	e child seen?	
	,		,	e			
If source is DO	CTOP LOODIN	TAL or CLINI	C what w	vas done, and wh	nat traatmant	was received?	
	C10K, HUSPH		C, what w	as uviit, allu WI	iat ti täliitelli	was i cuciveu !	

Show any additional sources on the following pages, one at a time. If you need more space, use Section 9. Remarks. When you finish listing all medical sources, go to Section 6 on page 9.

B. SECOND SOURCE

Is this source a:	Doctor	Hospita	l or Clinic	Agency	Other	(Specify)	
Name of Source			Address	(Number and Street, Ap	ot. No. (if any	· 1 • /	ural Route)
City				State		Zip Code	
Patient/Clinic/ID/0	Claim Number	(if known)	Name of	Counselor/Casework	er/Therapist	t (if any)	
Telephone Numbe	r		Please sh	ow the date of the chi	ild's next ap	pointment (if a	ny)
()			Month	Day		Year	
If this source is a c	loctor, agency	, or other, co	mplete the	information in the fol	lowing space	ce:	
Date first seen:				Date last seen:			
	Month	Day	Year		Month	Day	Year
Weekly I I Medical Specialty			hly 🖵 E	very two months	Quarterly	Less freq	uently
If this source is a l	HOSPITAL O	R CLINIC, V	was the child	d:			
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Beginning Date:				First Seen:			
Month	_ Day	Year		Month	_ Day	Year	
Ending Date:				Last Seen:			
Month	_ Day	Year		Month	_ Day	Year	
Department:				Department:			
				Show dates of any	emergency	room visits:	
				Month	_ Day	Year	
				Month	_ Day	Year _	
If source is DOC	ГOR, HOSPIT	AL or CLIN	IC, for wh	at illnesses or injur	ies was the	child seen?	
If source is DOC	ΓOR, HOSPIT	AL or CLIN	IC, <mark>what</mark> w	vas done, and what	treatment	was received	2
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C. THIRD SOURCE

Frequency of Visits: Weekly Every two weeks Monthly Every two months Quarterly Less frequently Medical Specialty (if doctor)	Patient/Clinic/ID/Claim Number (if known) Name of Counselor/Caseworker/Therapist (if any) Telephone Number Please show the date of the child's next appointment (if any) () Month Day Year If this source is a doctor, agency, or other, complete the information in the following space: Date first seen: Month Day Year Date first seen: Month Day Year Date last seen: Month Day Year Frequency of Visits: Month Day Year Month Day Year Less frequently Medical Specialty (if doctor)	Patient/Clinic/ID/Claim Number (if known) Name of Counselor/Caseworker/Therapist (if any) Telephone Number Please show the date of the child's next appointment (if any) () Month Day Year	Name of Source		Address	(Number and Street, A)	pt. No. (if any),	P.O. Box or Rural Rout
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	II SOURCE IS DOCTOR, HOSPITAL OF CLINIC, FOR What minesses or injuries was the child seen?				C for ruh			
		If source is DOCTOR, HOSPITAL or CLINIC, what was done, and what treatment was received?						
		If source is DOCTOR, HOSPITAL or CLINIC, what was done, and what treatment was received?						
		IT SOULD IS DOCTOR, HOSPITAL OF CLINIC, What was done, and what treatment was received?						
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D. FOURTH SOURCE

Is this source a: Doctor Hos	pital or Clinic	Agency	Other	(0,, (0,))
Nous of Courses	A J J			(Specify)
Name of Source	Address	(Number and Street, Ap	ot. No. (if any), P.O. Box or Rural Route)
City		State		Zip Code
Detiont/Clinic/ID/Cloim Number (if Imerur) Nome of			(if any)
Patient/Clinic/ID/Claim Number (if known	i) Name of	Counselor/Casework	er/Therapist	(II any)
Telephone Number	Please sh	ow the date of the chi	ld's next ap	pointment (if any)
()	Month _	Day		Year
If this source is a doctor , agency, or other	, complete the	information in the fol	lowing spac	e:
Date first seen:		Date last seen:		
Month Day	Year		Month	Day Year
Frequency of Visits:				
Weekly Every two weeks	Ionthly 🛛 E	very two months \Box	Quarterly	Less frequently
Medical Specialty (if doctor)				
If this source is a HOSPITAL OR CLINI	C, was the chil	d:		
An inpatient ? (stayed at least overnig If checked, enter the beginning and end		An outpatient If checked, ent		e the same day) first and last seen below.
Beginning Date:		First Seen:		
Month Day Yes	ar	Month	_ Day	Year
Ending Date:		Last Seen:		
Month Day Yes	ar	Month	_ Day	Year
Department:		Department:		
		Show dates of any	emergency	room visits:
		Month	_ Day	Year
		Month	_ Day	Year
If source is DOCTOR, HOSPITAL or CI	LINIC, for wh	at illnesses or injuri	ies was the	child seen?
If source is DOCTOR, HOSPITAL or CI	LINIC, what v	vas done, and what	treatment	was received?
		·		

E. FIFTH SOURCE

Name of Source		Address	(Number and Street, Ap	ot. No. (if any),	(Specify) P.O. Box or Rura	l Route)
N*.						
City			State		Zip Code	
Patient/Clinic/ID/Claim Nu	mber (if known)	Name of	Counselor/Casework	er/Therapist (i	f any)	
Selephone Number		Please sh	how the date of the chi	ild's next app	ointment (if any))
)			Day		•	
f this source is a doctor, a	gency, or other, c					
Date first seen:		-	Date last seen:	0.1		
	Day	Year		Month	Day	Year
Aedical Specialty (if doctors f this source is a HOSPIT						
An inpatient ? (stayed a If checked, enter the be	at least overnight))	An outpatient		the same day) rst and last seen	below
Beginning Date:			First Seen:			
Aonth Day	Year		Month	_ Day	Year	
Ending Date:			Last Seen:			
Month Day						
Department:			Department:			
			Show dates of any			
			Month Month	•		
f source is DOCTOR, HO	SPITAL or CLI	NIC, for wh	at linesses or injur	les was the c	niid seen?	
f source is DOCTOR, HO	SPITAL or CUI	NIC what v	vas done and what	treatment w	as received?	
	JULIAL OF CLI	what v	vas uune, anu what	u cauntint W		

F. SIXTH SOURCE

Name of Source		Address	(Number and Street, A	pt. No. (if any), P.O. Box or Rural Route
City			State		Zip Code
Patient/Clinic/ID/	Claim Number (if known)	Name of	Counselor/Casework	er/Therapist	(if any)
Telephone Numbe	er	Please sh	ow the date of the ch	ild's next ap	pointment (if any)
()		Month	Day		Year
If this source is a	doctor, agency, or other, co				
Date first seen:		-	Date last seen:		
	Month Day	Year		Month	Day Year
	y (if doctor)				
If this source is a	HOSPITAL OR CLINIC, v	vas the child			
-	? (stayed at least overnight) ter the beginning and ending	g dates.	An outpatient If checked, en		e the same day) first and last seen below
Beginning Date:			First Seen:		
Month	Day Year		Month	_ Day	Year
Ending Date:			Last Seen:		
Month	Day Year		Month	_ Day	Year
Department:			_		
			Show dates of any	emergency	room visits:
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If course is DOC	TOR, HOSPITAL or CLIN	IC, for wh	at illnesses or injur	ies was the	child seen?
II Source is DOC					
	TOR, HOSPITAL or CLIN	IC, what w	vas done, and what	treatment	was received?
	TOR, HOSPITAL or CLIN	IC, what w	vas done, and what	treatment	was received?

If you need more space, use Section 9. Remarks.

Section 6. Medications and Tests

A. Has the child taken any **medication** for an illness or injury?

Yes No

If **Yes**, please tell us the following:

Name of Medication	Prescribed By (Name of Health Care Professional)	Reason for Medication	Side Effects (If any)

B. Has the child had or is the child scheduled to have any of the following medical tests? YesIf Yes, please tell us the following:

🛛 No

Test	When	Done	When Se	cheduled	Where	Who Ordered Test?
(Check if Yes)	Month	Year	Month	Year	(Name of Facility)	Who Ordered Test?
EKG (heart test)						
Treadmill (exercise test)						
Cardiac Catheterization (heart test)						
Biopsy (Name part of body):						
U Vision test						
Hearing test						
Speech or language test						
□ IQ testing						

Test	When	Done	When Se	cheduled	Where	Will a Occilence d Tra-49
(Check if Yes)	Month	Year	Month	Year	(Name of Facility)	Who Ordered Test?
EKG (brain wave test)						
HIV test						
Other blood test						
Breathing test						
MRI (Name part of body):						
CAT Scan (Name part of body):						
X-Ray (Name part of body):						
Other tests (Name below):						
Other tests (Name below):						

Section 7. Other Sources

A.	Has the child ever been tested or evaluated by any of the following agencies (do not repeat medical test
	information from Question 6) or do any of these agencies have medical records or information about the
	child?

Public or Community Health Department	Yes	D No
Child Welfare or Social Services Agency	Yes	D No
Developmental Evaluation Center	Yes	D No
Mental Health or Mental Retardation Center	Y es	D No
Title V Program for Children with Special Health Care Needs	Y es	D No
Women, Infants and Children (WIC) Program	Yes	D No
Any Other Agency	U Yes	🔲 No

If you answered **Yes** to any of the above agencies, please **complete the following information for each agency**. If you need more room, enter the information in **Section 9. Remarks**.

Name of Agency				
Address	City		State	Zip Code
Name of Counselor, Caseworker, Therapist, et	cc. (if known)	Telephone N	umber	
Type of Test or Evaluation, if any (for exampl	e: vision, hearing, s	speech, physical, ps	sychological o	or emotional)
Child's ID or Claim Number	Dates of T	est or Evaluation		
Name of Agency				
Address	City		State	Zip Code
Name of Counselor, Caseworker, Therapist, et	c. (if known)	Telephone N	umber	
Type of Test or Evaluation, if any (for exampl	e: vision, hearing, s	speech, physical, ps	sychological o	or emotional)
Child's ID or Claim Number	Dates of T	Dates of Test or Evaluation		
Name of Agency				
Address	City		State	Zip Code
Name of Counselor, Caseworker, Therapist, etc. (if known) Telephone Number				
Type of Test or Evaluation, if any (for exampl	e: vision, hearing, s	speech, physical, ps	sychological o	or emotional)
Child's ID or Claim Number	Dates of T	est or Evaluation		

- B. Has the child been cared for by a **babysitter**:
 - **YES** (Complete information to right)
 - **NO** (Continue to next question)

C. Has the child attended any type of **preschool**, **daycare**, **or after school program**?

YES (Complete information to right)

NO (Continue to next question)

D. Has the child **attended school**?

YES (Complete information to right) If there are more than two schools, enter the information in **Section 9. Remarks**.

Name of E	Babysitter				
Street Add	ress				
City			State		Zip Code
Telephone	Number		I		
()					
Dates atter					
From:	Month	Year	To:	Mo	nth Year
Name of P	rogram				
Street Add	ress				
City			State		Zip Code
Telephone	Number				
()					
Dates atter					
From:	Month	Year	То:	Mo	nth Year
Name of S	chool				
Street Add	ress				
City			State		Zip Code
Telephone ()	Number				
Dates atter	nded:				
From:	Month	Year	To:	Mo	nth Year
Grades					
Teacher's	Name				

D. Continued

Street Address	8					
City			State	e	Zip Code	
Telephone Nu	mber					
()						
Dates attended	1:					
From: M	onth	Year	To:	Mont	ih Y	/ea
Grades						
Teacher's Nan	ne					
Type of Prog	ram					
Dates began an	nd ended	(if comple Year	ted): To:	Mont	- L X	/ea
From: M	onui	I ear	10:	MOIN	.11 1	ea
Number of hor	urs per we	eek:				
	1					
Type of Acco	mmodati	on				
- J F						
Date the accor	nmodatio	n started:		Mont	th Y	/ea
NT 1.4	n of Area	Education	n Agenc	y that ha	as child's	
Name and tow				-		
Name and tow records	ii oi i iicu	Baavation	C			
	n or rnou		C			

E. Has the child been in a special education program?

YES (Complete information to right)

NO (Continue to next question)

F. **Has the school made any other special accommodations** for the child? (for example: adaptive furniture, wheelchair ramps, extra assistance or attention)

YES (Complete information to right)

NO (Continue to next question)

G. Do you have a copy of the child's **individualized education plan (IEP)**, the report in which the teacher outlines the child's problems and lists the plans for correcting them?



H.	Has the child received any special counseling or					
	tutoring?	☐ In school ☐ Outside of sch	ool			
	YES (Complete information to right)	Type of Counseling or Tutoring				
	NO (Continue to next question)	Name of Counselor or Tutor				
		Street Address				
		City	State	Zip Code		
		Telephone Number				
		Dates began and ended (if completed):				
		From: Month Year		onth Year		
		Frequency of visits:				
I.	Does the child or family have a child welfare, social services or early intervention	Name of Caseworker				
	caseworker?	Organization				
	YES (Complete information to right)NO (Continue to next question)	Street Address				
		City	State	Zip Code		
		Telephone Number				
		File or Record Number				
		Date first saw caseworker:	Мс	onth Year		
		Date last saw caseworker:	Мс	onth Year		

Do you have a copy of the child's **individualized family services plan (IFSP)**, the report that identifies the child's needs and the services to be provided to help the child develop? J.



YES (Please provide a copy)

K. Has the child received any **special therapy** (physical, speech and language, occupational), **exercises**, **or any other services** for the child's illnesses or injuries? Include information about any therapy or exercises the child receives from the parent, guardian, a caregiver, or in school.

YES (Complete information to right)

Name of Therapist				
Street Address				
City	State		Zip Coo	de
Telephone Number				
() Person Who Prescribed Designed Therap	у			
Type of Therapy				
Frequency of Therapy				
Date therapy began:		Month	1	Year
Date therapy ended (if completed):		Month	1	Year
Name of Therapist				
Street Address				
City	State		Zip Coo	de
Telephone Number				
() Person Who Prescribed Designed Therap	У			
Type of Therapy				
Frequency of Therapy				
Date therapy began:		Month	1	Year

L.	Has the child ever worked (including sheltered work)?	Employer's Name				
	YES (Complete information to right)	Supervisor or Job Coach's Name				
	NO (Continue to next question)	Street Address				
	-	City	State	Zip Code		
	If Yes , has the child worked since the child became disabled?	Telephone Number				
	YES (Complete information to right)	() Briefly describe the work:				
	NO (Continue to next question)					
M.	Has the child received vocational rehabilitation services ?	Name of Counselor				
	YES (Complete information to right)	Street Address				
	D NO (Continue to next	City	State	Zip Code		
	question)	Telephone Number				
	If No , and the child is at least age					
	15, would the child like to be referred for rehabilitation or other	Type of Service Received				
	services that could help the child get a job?	Date service began:	Montl	h Year		
		Date service ended (if completed):	Montl	h Year		

Has the child ever been involved with the court system other than in	Youth Development Center's Name				
custody proceedings?	Street Address				
YES (Complete information to right)	City	State	Zip Code		
NO (Continue to next question)	Probation or Parole Officer's Name				
Note: Providing information about the child's involvement	Street Address				
with the court system is optional.	City	State	Zip Code		
	Telephone Number	1			
	How Often Involved				
	Date last seen:	Mont	h Year		
Has the child participated in any community or school activities ,	Type of Activity				
such as choir, boy's or girl's club, scouts, or sports?	Name of Individual Who Supervises Activity				
YES (Complete information to right)	Street Address				
NO (Continue to next question)	City	State	Zip Code		
	Telephone Number				
	Date involvement began:	Mont	h Year		
	Date involvement ended (if completed):	Mont	h Year		
	If involvement ended, explain why:				
	 with the court system other than in custody proceedings? YES (Complete information to right) NO (Continue to next question) Note: Providing information about the child's involvement with the court system is optional. Has the child participated in any community or school activities, such as choir, boy's or girl's club, scouts, or sports? YES (Complete information to right) NO (Continue to next 	Has the child participated in any community or school activities, such as choir, boy's or girl's club, scouts, or sports? Type of Activity Type of Activity Street Address City Telephone Number (Image: Construct of the other than in custody proceedings? Street Address YES (Complete information to right) Street Address No (Continue to next question) Probation or Parole Officer's Name Note: Providing information about the child's involvement with the court system is optional. Street Address City State Probation or Parole Officer's Name Street Address City State Telephone Number (

Section 8. Contact Information

A. Please give us the name, address, and daytime telephone number of **someone** (other than the child's doctor) who knows about the child's illnesses or injuries and can help you, if necessary, with the child's claim, including perhaps, bringing the child to a special examination:

Nan	ne	Street Address (Number and Street, Apt. No. (if any), P.O. Box or Rural Route)				
City			State	Zip Code		
Daytime Telephone Number						
В.	Can we discuss the child's illnesses	s or injuries with this person?		n is related to the is the relationship?		
	D No					

Section 9. Remarks

Section 9.	Remarks (Continued)
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Section 10. Remarks and Authorization

READ CAREFULLY: I authorize the Department of Human Services to release information from my records, as necessary, to process my claim as follows:

- Copies of my medical records including any mental health information or substance abuse information may be furnished to a physician or a medical institution for background information if it is necessary for me to have a medical examination by that physician or medical institution. The results of any such examination may be given to my personal physician.
- Information from my records including any mental health information or substance abuse information may also be furnished, if necessary, to any company providing any clerical and administrative services for the purposes of transcribing, typing, copying or otherwise clerically servicing such information. Iowa Vocational Rehabilitation Services may also have access to information in my records to determine my eligibility for rehabilitative services.

I understand that I may review the disclosed information by contacting the agency or individual releasing the information.

I understand and concur with the statement and authorization given above, except as follows:

(If there are no exceptions, write **none** in the space below. If you do not concur with any part of the above statement, state your objections clearly):

I have signed two *Authorization to Disclose Information to the Iowa Department of Human Services*, form 470-4459 or 470-4459(S). It has been explained to me that these blank authorizations will be used for additional medical sources that DDS becomes aware of in processing my claim. It is agreeable with me for DDS to complete the authorization with the name and address of the medical source and the date of treatment.

I understand that this authorization, except for action already taken, may be voided by me at any time by submitting a written request to the Department of Human Services. If I do not void this authorization, it will automatically end when a final decision is made on my application. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

Applicant's Name (please print)		Date
Applicant's Signature		Date
Telephone Number (daytime)	Telephone Number (evening)	Best time to reach you?
()	()	
Applicant's Legal Representative's Signat	ture	

Only a claimant 18 years of age or older, or legal representative, can authorize release of mental health information. Only the claimant, regardless of age, can authorize release of substance abuse information.

Original – Disability Determination Services Copy – DDS forwards to medical source Copy – Client

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