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MEDICAID ELIGIBILITY  
FORMS AND INSTRUCTIONS

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**DOM-323A - DISABLED CHILD QUESTIONNAIRE**

**PURPOSE & USE**

This form is completed along with DOM-323 for all applicants age 18 and under. This form records pertinent medical and educational information for the child. The form is completed by the parent or representative or the Specialist based on the parent/representative's responses.

**INSTRUCTIONS**

Prepare an original. Submit DOM-323, 323A and any prior medical information to DDS in accordance with procedures outlined in the Blindness and Disability policy in Section D.

The parent or representative of the child must sign and date the form upon completion.



\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Does the child or family have a social services or early intervention caseworker? If yes,

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone # \_\_\_\_\_ File # \_\_\_\_\_

5. Has the child ever been tested or evaluated by any of the following?

Public/ Community Health/ Social Services Dept.  Yes  No

Developmental Evaluation Center  Yes  No

Community Mental Health Center  Yes  No

Speech and Hearing Center  Yes  No

Women, Infants & Children (WIC) Program  Yes  No

If yes to any of the above, provide the agency name, address & telephone # below. Also state the type of test or evaluation performed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Does or has the child received physical therapy, occupational therapy, or speech & language therapy outside the home?

Yes  No If yes, state the type and frequency of the treatment and the name, address & telephone # of the therapist.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Does or has the child received any special therapy, exercises, or any other services for disability at home?  Yes  No  
If yes, state the type and frequency of the treatment and the

name, address & telephone number of the therapist. Indicate if any medication included.

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8. Does or has the child received rehabilitation services?  
\_\_ Yes \_\_ No If yes, describe services received and the name, address & telephone # of the rehabilitation counselor.

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9. If the child takes any medication on an ongoing, routine basis, please indicate the following:

Name(s) of medication: \_\_\_\_\_

Dosage and Amount: \_\_\_\_\_

Frequency: \_\_\_\_\_

Prescribed by: \_\_\_\_\_

Address/ Telephone \_\_\_\_\_

What are medications for: \_\_\_\_\_

Side effects \_\_\_\_\_

Does medication work? \_\_\_\_\_

10. Has the child ever been involved with the court system?  
\_\_ Yes \_\_ No THIS INFORMATION IS OPTIONAL.

If yes, please explain involvement: \_\_\_\_\_

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Name of Youth Court or Probation/Parole Officer (include address & telephone #.)

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