GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director **MDL # 21-02B**

PARENT/CARETAKER QUESTIONNAIRE

Child's Name: (Last, First, Middle)

Medicaid ID Number:

Date of Birth:

Phone Number:

Date:

The information you provide below will be helpful in deciding if the child has a disability that would make him/her eligible for the Child and Adolescent Supplemental Security Income Program (CASSIP). Please leave blank any item for which you do not have information or that would not otherwise apply.

Have you noticed any problems in the child's ability to move or walk? If yes, please describe:

Have you noticed any problems in how the child acts around other people (including you, family members, relatives, strangers)? If yes, please describe:

Have you noticed any speech problems? If yes, please describe:

Have you noticed any problems in self-care activities such as going to the toilet, washing, feeding, dressing, etc.? If yes, please describe:

Have you noticed any problems in how the child plays, either by himself or with others? If yes, please describe:

Have you noticed any behavior problems? If yes, please describe: