New Jersey Department of Human Services
Pediatric Medical Day Care Services

PRIMARY HEALTH CARE PROVIDER REPORT ON MEDICAID BENEFICIARY

IDENTIFYING INFORMATION

1. Name of Beneficiary (Last, First, MI): _____

   Address: _____

   _____

   Telephone Number: _____

2. Sex: ☐ Male ☐ Female Age: _____ Birthdate: _____

3. Medicaid Number: _____

4. Social Security Number: _____

5. Name of Parent/Guardian: _____

   Address (if different from child's): _____

   _____

   Telephone Number: _____

   Cell Phone Number: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize _____ to disclose health information and release the medical records of _____ , the applicant/beneficiary to the New Jersey Department of Human Services, as may be requested, for the purpose of determining eligibility for Pediatric Medical Day Care services.

Signature: _____ Date: _____
(Parent or Other Legal Representative)

HEALTH INFORMATION

1. **History** *(attach additional sheet if needed)*

PRIMARY HEALTH CARE PROVIDER REPORT ON MEDICAID BENEFICIARY
(Continued)

2. **Diagnosis**

1. _____

2. _____

3. _____

(Add attachment for additional diagnoses)

3. **Medications**

Name	Dosage	Route	Frequency

4. **Treatment Procedure/Plan**

Type	Frequency

5. Does child attend school? ☐ Yes ☐ No If Yes, number of days per week: _____

6. Does child receive other services?

☐ Private Duty Nursing ☐ Yes ☐ No

If Yes, number of days per week: _____ Number of hours per day: _____

☐ Home Health Care ☐ Yes ☐ No

If Yes, number of days per week: _____ Number of hours per day: _____

☐ Early Intervention ☐ Yes ☐ No

If Yes, attach copy of the latest IFSP.

7. Does child have special transportation needs? ☐ Yes ☐ No

If yes, describe:

_____

_____

PRIMARY HEALTH CARE PROVIDER REPORT ON MEDICAID BENEFICIARY
(Continued)

8. Nursing care needs (check all appropriate on list):

Nutrition
- ☐ Regular Diet
- ☐ Special Diet
- ☐ Diabetic Shots
- ☐ Formula-Special
- ☐ N/G tube/G-tube/J-tube
- ☐ Slow Feeder
- ☐ FTT or Premature
- ☐ Hyperalimentation

Elimination
- ☐ Appropriate for age
- ☐ Bowel Incontinence (age >3)
- ☐ Urine Incontinence (age >3)
- ☐ Ostomy, type: _____
- ☐ Catheterization
- ☐ Home Dialysis
- ☐ Other (describe) **

Cardiopulmonary Status
- ☐ Monitoring Only
- ☐ CPAP/Bi-PAP
- ☐ CP Monitor
- ☐ Pulse Ox
- ☐ Vital signs >2/day
- ☐ Oxygen Therapy
- ☐ Vent
- ☐ Trach
- ☐ Nebulizer Tx
- ☐ Suctioning
- ☐ Chest Physical Tx

Mobility
- ☐ Appropriate for age
- ☐ Prosthesis
- ☐ Splints
- ☐ Non ambulatory >18 months old
- ☐ Wheelchair

Behavioral/Developmental
- ☐ Appropriate for age
- ☐ Hyperactive
- ☐ Cooperative
- ☐ Alert
- ☐ Developmental Delay
- ☐ Mental Retardation
- ☐ Behavioral Problems*
- ☐ Verbal
- ☐ Non-Verbal

Integument
- ☐ Normal
- ☐ Burn Care
- ☐ Sterile Dressings
- ☐ Decubiti
- ☐ Eczema-Severe
- ☐ Other **

Neurological Status
- ☐ Normal
- ☐ Deaf
- ☐ Blind
- ☐ Seizures
- ☐ Paralysis
- ☐ Neurological Deficit (describe)

* Please describe Behavioral Problems, if checked: _____

_____

_____

** Other, describe: _____

_____

_____

9. Name of Physician/Provider *(Print)*: _____

Address: _____

_____

Telephone Number: _____

Fax Number: _____

Signature of Physician: _____

Date Signed: _____