State of Florida
Department of Children and Families

Rick Scott
Governor

Mike Carroll
Secretary

Date: ___________

Medically Complex Child – Intake

Child's Name: **DOB:** **Intake #**

PCP: ____

Diagnoses:

____
____
____
____
____

Specialists:

____
____

People who live in the home:	

Insurance	**Company**	**Case Manager**	**Phone #**
Primary			
Secondary			

SSI:	Medicaid Waiver Program:
☐ Date Applied: ________________	☐ Date Applied: ________________
☐ Date Approved: ________________	☐ Date Approved: ________________

Programs	**Name/Location**	**Phone#**	**Effective Dates**	**N/A**
Early Intervention				
School:				
Teacher:				
Hospice/Palliative Care				

Therapy & Equipment	Company/Provider	Phone	Frequency	N/A
DME Provider				
Mobility Provider				
Physical Therapy			_____x/week	
Occupational Therapy			_____x/week	
Speech Therapy			_____x/week	
Communication Equipment				
Home Nursing			_____hr/day	

*DME = Durable Medical Equipment

Transportation	☐ Self	☐ Medicaid	☐ Medical Transport
Handicap sticker:			
Transport Co:			

Parental Understanding Assessment	Yes	No	Special Circumstance Notification
Does family know or have written down this information?			Electric Co ☐ Sent, Date: __________
Are they able to tell you the next appointments?			Fire Dept: ☐ Sent, Date: __________
Have there been any missed appointments?			Telephone Co: ☐ Sent, Date: __________
Any hospitalizations?			Water Co: ☐ Sent, Date: __________
Home nursing no-shows?			Disaster Plan: ☐ Sent, Date: __________

Potential Challenges for Successful Home Management: