DC Healthy Families

Because some of the best things in life are free.

Government of the District of Columbia
Muriel Bowser, Mayor

WE ARE WASHINGTON DC

Call us if you do not speak or read English.

Amharic: እንግሊዝኛ መናገር ወይም ማንበብ የማይችሉ ከሆነ ይደውሉልን.
Chinese: 如果您不會講英語或不會閱讀英語，請打電話告訴我們。
French: Appelez-nous si vous ne parlez pas ou ne savez pas lire l'anglais.
Korean: 영어로 말하거나 읽는데 어려움이 있으면 전화주십시오.
Spanish: Llámenos si no habla ni lee inglés.
Vietnamese: Hãy gọi chúng tôi nếu quý vị không nói hoặc đọc tiếng Anh.

Child and Adolescent Health Measurement Index (CAHMI Form)

Health Care Needs of Children in DC Medicaid

If your child has special health care needs, please tell us about them. Your health plan will use this information to give your child the best care. Thank you!

Please complete a separate form for each child in your household who is under age 21. Make extra copies if you need them. Mail the form to us in the enclosed envelope.

(202) 639-4030 or (800) 620-7802
Call us if you need help in any language.
TTY/TDD Line: (202) 639-4041

Mail the form to us in the enclosed envelope.

You can fill out this form online.
It's fast and easy.
www.DCHealthyFamilies.com

		Head of Household	Child
Name	*First*		
	Middle		
	Last		
Birth date	*(mm/dd/yyyy)*	/ /	/ /
Home address	*Street*		
	Apt #		
	City		
	State and Zip		
Medicaid number		#	#

Q1. Does this child have any health problems or medical treatments your health plan should know about?

❑ **Yes** ❑ **No** → *Skip to Q2*

1a. [IF YES] Please describe (any health problems or medical treatments): _____

_____

_____

_____

_____

_____

Q2. Is this child pregnant?

❑ **Yes** ❑ **No** → *Skip to Q3*

2a. [IF YES] What is the name of her doctor?

_____

2b. What is her expected delivery date (if known)?

_____ *(mm/dd/yyyy)*

Q3. Does your child currently need or use medicine prescribed by a doctor (other than vitamins)

❑ **Yes** ❑ **No** → *Skip to Q4*

3a. [IF YES] What are the names of these medications? (Please check bottle if unsure of name.)

Specify: _____

_____

_____

_____

_____

_____

3b. Does your child need or use these medications because of a condition that has lasted, or is expected last, for at least one year?

❑ **Yes**

❑ **No** → *Skip to Q4*

More questions on the back. →

For the remaining questions, please check the box that best describes your answer.
Continue to the next row for the next item unless there is an instruction to skip to another item.

Check one for each item below, as directed.

Yes **No** **Don't know**

Q4. Does your child need or use more medical care, mental health, or educational services than is usual for most children of the same age?

❑ *1* ❑ *2* → Skip to Q 5 ❑ *8* → Skip to Q 5

4a. [IF YES] Is this because of any medical, behavioral, or other health condition?

❑ *1* ❑ *2* → Skip to Q 5 ❑ *8* → Skip to Q 5

4b. [IF YES] Has this condition lasted, or is it expected to last, for at least one year?

❑ *1* ❑ *2* ❑ *8*

Q5. Is your child limited or prevented in any way in [his/her] ability to do things most children the same age can do?

❑ *1* ❑ *2* → Skip to Q 6 ❑ *8* → Skip to Q 6

5a. [IF YES] Is this because of any medical, behavioral, or other health condition?

❑ *1* ❑ *2* → Skip to Q 6 ❑ *8* → Skip to Q 6

5b. [IF YES] Has this condition lasted, or is it expected to last, for at least one year?

❑ *1* ❑ *2* ❑ *8*

Q6. Does your child need or get special therapy, such as physical, occupational, or speech therapy?

❑ *1* ❑ *2* → Skip to Q 7 ❑ *8* → Skip to Q 7

6a. [IF YES] Is this because of any medical, behavioral, or other health condition?

❑ *1* ❑ *2* → Skip to Q 7 ❑ *8* → Skip to Q 7

6b. [IF YES] Has this condition lasted, or is it expected to last, for at least one year?

❑ *1* ❑ *2* ❑ *8*

Check one for each item below, as directed.

Yes **No** **Don't know**

Q7. Does your child have any kind of emotional, developmental, or behavioral problem?

❑ *1* ❑ *2* → Skip to Q 8 ❑ *8* → Skip to Q 8

Q7a. [IF YES] Does your child need or get treatment or counseling for this problem?

❑ *1* ❑ *2* → Skip to Q 8 ❑ *8* → Skip to Q 8

Q7b. [IF YES] Has this problem lasted, or is it expected to last, for at least one year?

❑ *1* ❑ *2* ❑ *8*

Q8. Does this child have any special medical procedures that have already been scheduled? Examples include chemotherapy, surgery, allergy shots, or other therapy of any kind.

❑ *1* ❑ *2* ❑ *8*

FOR OFFICE USE:

Child's Medicaid Number: _____

Date form completed: _____

Plan Name: _____

Broker Employee Name: _____