NEW YORK STATE DEPARTMENT OF HEALTH
State Disability Review Unit

Description of Child's Activities

Child's Name: (Last, First, Middle)	**Case Number:**	**Date of Birth:**
Agency: State Disability Review Unit 8th Floor OCP State of New York Department of Health Albany, NY 12237	**Client ID Number:**	**Disability ID Number:**
	Sex: ☐ **Male** ☐ **Female**	
	Worker Name:	
	Phone Number: 1-866-330-0591	**Date:**

An application for benefits based on disability status has been filed on behalf of the above-named child. The information you provide below will be helpful in deciding if the child will receive Medicaid based on disability. Please leave blank any item for which you do not have information or that would not apply because of the child's age. Thank you for your assistance.

Have you noticed any problems in the child's ability to move or walk? ☐ No ☐ Yes
If yes, please describe:

Have you noticed any problems in how the child acts around other people (including you, family members, relatives, strangers)? ☐ No ☐ Yes
If yes, please describe:

Have you noticed any speech problems? ☐ No ☐ Yes

If yes, please describe:

Have you noticed any problems in self-care activities such as going to the toilet, washing, feeding, dressing, etc.? ☐ No ☐ Yes

If yes, please describe:

Have you noticed any problems in how the child plays, either by himself or with others? ☐ No ☐ Yes

If yes, please describe:

Have you noticed any behavior problems? ☐ No ☐ Yes

If yes, please describe:

Please complete the following if the child goes to school.

Name of School:	
Teacher's Name:	**Grade:**
Is this a special education program of some type? ☐ No ☐ Yes If yes, please describe:	
Does the child need special or extra help regarding school? ☐ No ☐ Yes If yes, please describe:	
Do you know of any problems concerning the child's school attendance or performance such as truancy, days absent due to illness, fighting, failing grades or discipline problems? ☐ No ☐ Yes If yes, please describe:	
Please add any other comments or information you have regarding school performance:	

Your Name:
Relationship to Child:
Telephone Number: