KDHE Program Visit Form - Infant/Child/Adolescent

Which Child was involved (Client Name):

_____

Date of Activity: _____/_____/_____

Agency/Clinic: _____

Client Address: _____

City: _____ **Zip Code:** _____

County of Residence: _____

Phone No: _____ - _____ - _____

Email: _____

Preferred Method of Contact: (check all that apply)

- ☐ Phone call
- ☐ Text
- ☐ Email
- ☐ Mail
- ☐ Do Not Contact

Program: (select one)

- ☐ Maternal Child Health (MCH/M&I)

Primary Healthcare Coverage: (select one)

- ○ None/Self Pay
- ○ Private Insurance
- ○ Tricare
- ○ KanCare/Medicaid
- ○ CHIP (Formerly HealthWave)
- ○ Medicare (client is on disability)
- ○ Unknown/Not Reported

Secondary Healthcare Coverage: (select one)

- ○ None
- ○ Private Insurance
- ○ Tricare
- ○ KanCare/Medicaid
- ○ CHIP (Formerly HealthWave)
- ○ Medicare (client is on disability)
- ○ Unknown/Not Reported

Has the client had a well visit during the last 12 months? (With any provider, not just within the program)

- ○ Yes
- ○ No
- ○ Client is unsure

Does the Child have a Medical Home?

- ○ Yes
- ○ No

Does the client have a special health care need or disability? (Has a medical diagnosis or requires care beyond general preventive care)

- ○ Yes
- ○ No

If yes, Is the child needing a medical diagnosis?

- ○ Yes
- ○ No

If No, Was the child diagnosed through the Newborn Screening Testing?

- ○ Yes
- ○ No

If No, Does the child have any of the following conditions?

- ☐ Craniofacial
- ☐ Neurological
- ☐ Seizures
- ☐ Hydrocephalus or Microcephaly
- ☐ Orthopedic Needs
- ☐ Spinal Bifida
- ☐ Hearing Loss
- ☐ Juvenile Rheumatoid Arthritis
- ☐ Cardiac Condition
- ☐ Hemophilia
- ☐ Glaucoma
- ☐ Congenital Cataract, or Retinal Disorder
- ☐ Gastrointestinal or Genitourinary Diagnosis
- ☐ Other

Specify Other SHCN Condition(s):

_____

Household Size: (number of people) _____

Annual Household Income: $_____

Annual Household Income: (select range)

- ○ Less than $10,000
- ○ $10,000 to $14,999
- ○ $15,000 to $19,999
- ○ $20,000 to $24,999
- ○ $25,000 to $34,999
- ○ $35,000 to $49,999
- ○ $50,000 or more
- ○ Don't Know
- ○ Refused

Visit In-Person or Virtual?

- ○ In person
- ○ Virtual, phone call only
- ○ Virtual, video chat (Skype, Zoom, FaceTime, etc.