

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.)