Medical Review Team (MRT)
Slot S334
Social Report for Children

Section 1: To be completed by Eligibility Worker

Child's Budget Unit ID	Cat.	Child's Name	Race	Sex	Birthdate
Application Date	County	Register #	Casehead Name		
Address	City	State	Zip		
Worker's Name as shown on E-Mail	Last MRT decision date	Interview Date	Date routed To MRT		

Section 2: MRT use only

Date Record Added	MRT Date	Date Medical Records Request Sent Code Records Rec'd	Physician Date ID	Decision Date Code
Re-exam Date	Case Type	Key Initial	Key Date	

Section 3: To be completed by Eligibility Worker, Parent or Guardian

A. List all Household Members:

Last Name	First Name	Relationship	Age
		Child	

Daytime Phone # and Area Code:	
Home/Mobile Number:	Message Number:

B. Description of Physical & Mental Condition: Please ask the parent or caretaker the following questions:

1. What is the child's height? __ Weight?
2. When did the illness, injury, or condition begin? MM/DD/YY_________________________
3. Has the child ever received or applied for SSI or Social Security Disability? Yes___ (Go to 3a) No___ (go to #4)
   a. Is SSI/SSA application still pending? Yes_____ (Go to #4) No_____ (Go to 3b)
   b. What were the dates of approval, denial, or closure? _________________________________
   c. What was the reason for denial or closure? Please provide a copy of letter from Social Security Administration stating the reason for denial/closure.

   d. If it has been more than 12 months since the last SSI or Social Security Disability denial/closure, is the condition with SSA last considered about the same, better, worse, or has it changed?

4. Describe any medical conditions or injuries that limit the child's daily life.

5. Describe any behavior problems, speech problems, learning problems, or attendance problems the child has had at home, in school or therapy.

6. **Education/Therapy/Medical Treatment**
   a. What medical treatment has the child received for this condition? What Treatment is planned for the future?

   b. Does the child attend special education classes? Yes_____ No_____ List all schools/facilities that the child received behavioral, occupational, physical or speech therapy in the last year.
   Attach signed DHS-4000.
   ****If you have copies of therapy and/or evaluation records, please attach copies.**

School/Facility Information

Name of school/facility:			Grade:
Address:	City:	State:	Zip:
Area Code & Phone #:	Teacher:		

Name of school/facility:			Grade:
Address:	City:	State:	Zip:
Area Code & Phone #:	Therapist:		

Name of school/facility:			Grade:
Address:	City:	State:	Zip:
Area Code & Phone #:	Therapist:		

Physician/Clinics/Mental Health/Hospital Information (If you have copies of medical records from the past year to present, please attach copies)

Primary Care Physician Name:		Dates: From To	
Address:	City:	State:	Zip:

Area Code & Phone #:

Physician Name/ Clinic:		Dates: From To	
Address:	City:	State:	Zip:
Area Code & Phone #:			

Physician Name/Clinic:		Dates: From To	
Address:	City:	State:	Zip:
Area Code & Phone #:			

Physician Name/Clinic:		Dates: From To	
Address:	City:	State:	Zip:
Area Code & Phone #:			

Physician Name/Clinic:		Dates: From To	
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Area Code & Phone #:			

Physician Name/Clinic:		Dates: From To	
Address:	City:	State:	Zip:
Area Code & Phone #:			

Please check attachments:

- ☐ DHS-4000's completed for all necessary medical record requests
- ☐ DCO-107, if applicable
- ☐ Medical records, if available