Tennessee Department of Children's Services

Special Needs Justification

TO BE COMPLETED BY THE LICENSED PROVIDER, BOARD-CERTIFIED ABA PROVIDER, OR TEIS PROVIDER WHO IS PROVIDING THE SERVICES TO THE CLIENT AS DESCRIBED AND DOCUMENTED ON THIS FORM.

1. CLIENT IDENTIFYING INFORMATION:

Client Last Name:	Client First Name:	Date of Birth:	Address:

2. CLIENT WELL-BEING

2a. Date of most recent visit/appointment?

2b. What were the results of the visit/appointment?

2c. Were there any concerns and/or recommendations noted during the visit?

PROCEED TO QUESTION #19 IF THE CLIENT DOES NOT HAVE ANY MEDICAL OR MENTAL HEALTH DIAGNOSES WHICH REQUIRE ONGOING TREATMENT AND CARE

3. CLIENT DIAGNOSIS OR DISABILITY		PRIMARY SYMPTOMS OF DIAGNOSIS OR DISABILITY	LEVEL OF SEVERITY
☐ Physical/Medical ☐ Behavioral ☐ Other	1.		☐ Mild ☐ Moderate ☐ Severe
☐ Physical/Medical ☐ Behavioral ☐ Other	2.		☐ Mild ☐ Moderate ☐ Severe
☐ Physical/Medical ☐ Behavioral ☐ Other	3.		☐ Mild ☐ Moderate ☐ Severe
☐ Physical/Medical ☐ Behavioral ☐ Other	4.		☐ Mild ☐ Moderate ☐ Severe
☐ Physical/Medical ☐ Behavioral ☐ Other	5.		☐ Mild ☐ Moderate ☐ Severe
☐ Physical/Medical ☐ Behavioral ☐ Other	6.		☐ Mild ☐ Moderate ☐ Severe

4a. Does the Medical/Mental Health Condition or Developmental Delay SUBSTANTIALLY LIMIT the Client in one or more Major Life Activities? ☐ Yes ☐ No

If Yes, Check all that apply and provide a Detailed Explanation in **4b.**below.

☐ Walking	☐ Speaking	☐ Breathing	☐ Working	☐ Learning	☐ Performance of Manual Tasks
☐ Hearing	☐ Self-Care	☐ Social Skills	☐ Vision	☐ Interpersonal Relationships	
☐ **OTHER:**					

4b. Explanation:

5a. Are you, as the client's licensed provider, board-certified ABA provider, or TEIS provider providing/prescribing any ongoing treatment and/or extra care (medical/behavioral/emotional)?	☐ Yes	☐ No

5b. If yes, please describe, in detail, the ongoing treatment or extra care needed. (This includes medication, therapy, rehabilitation, etc.)

6. Are the treatment and services provided IN HOME or OUT OF HOME?	☐ IN HOME	☐ OUT OF HOME

7. Indicate the Estimated Frequency of treatment needed for the patient/client (i.e. therapy 3x per week):

8. Does the patient/client require a level of supervision exceeding that of his or her peers?	☐ Yes	☐ No

If yes, please provide a detailed explanation:

9a. Is the client considered to be a risk to themselves or the community?		☐ Yes	☐ No
9b. If Yes, indicate the level of risk:	☐ Mild Risk	☐ Moderate Risk	☐ High Risk
9c. If Yes, how recently have these behaviors occurred?	☐ Within the last 6 months	☐ Within 7-12 months	☐ 1 year ago or beyond
9d. If the client is considered to be at risk to themselves or the community, are you the licensed provider, board-certified ABA provider, or TEIS provider providing treatment or services to the client due to the at-risk behaviors?		☐ Yes	☐ No
10. Does the client have any life-threatening medical need or condition?		☐ Yes	☐ No

11a. How long has this patient/client been under your care?	**Start Date:**	
11b. Is the patient/client still under your care?	☐ Yes	Next Scheduled Appointment:
	☐ No	Date of Discharge from Services:

12. Has the patient/client participated in treatment as recommended in #5, consistently?	☐ Yes	☐ No

13. Please list or attach a copy of the patient's appointments and dates of service.

14. Please indicate the primary goal of treatment.

15a. Is the caregiver's participation required in the patient/client's treatment plan?	☐ Yes	☐ No

15b. What is the specific role of the caregiver in the patient/client's treatment plan?

15c. If yes, how often is the caregiver's participation required?	☐ Daily	☐ Weekly	☐ Twice a Month	☐ Monthly

15d. If daily, how many hours does the caregiver provide medically prescribed therapy or procedures?	☐ Less than 1 hour daily	☐ 1 hour daily	☐ 2 hours daily	☐ 3 hours daily	☐ 4 hour or more daily

16. Do you anticipate hospitalization (s)?	☐ Yes	☐ No

17. What is the patient/client's prognosis?

18. Is the patient/client currently prescribed medication?	☐ Yes	☐ No

If yes, please list the medications and dosage below.

MEDICATION	DOSAGE	ROUTE

19. Licensed Provider, Board-Certified ABA Provider, or TEIS Provider Information

Licensed Provider, Board-Certified ABA Provider, or TEIS Provider:
PRINT NAME AND CREDENTIALS

Licensed Provider, Board-Certified ABA Provider, or TEIS Provider: **SIGN:**	**DATE:**

Phone Number of Licensed Provider, Board-Certified ABA Provider, or TEIS Provider:	**AGENCY/ORGANIZATION NAME:**

TCA 36-1-204
Whoever knowingly obtains, or attempts to obtain, or aids, or abets any person to obtain, by means of a willfully false statement or representation or by impersonation, or other fraudulent device, any assistance on behalf of a child or other persons pursuant to the Interstate Compact on Adoption and Medical Assistance to which such child or other person is not entitled or assistance greater than such child or other person is entitled, commits a Class E felony.

Thank you for your time and cooperation completing this document. If additional information is needed to ensure that this child's medical and psychological needs are adequately documented, attach additional pages and/or documentation. If you have any questions, feel free to contact the worker requesting completion of this form.