TEXAS Health and Human Services

Texas Department of State Health Services

Children with Special Health Care Needs
Family Needs Assessment

Date of Assessment:	Client Name:	DOB:
Site of Assessment: ☐ Home ☐ Office ☐ Other, specify:		

Names of Household Members	Relationship to Client	Age
Others in the Client's Network of Care		

INDICATE OTHER HOUSEHOLD MEMBERS RECEIVING CASE MANAGEMENT SERVICES WITH AN ASTERISK (*).

CLIENT - HEALTH STATUS		
Diagnosis	**Primary**	
	Secondary	
Describe how the client's health condition, or health risk impacts the client and his or her family:		
DESCRIBE ANY NEEDS OR CONCERNS IN EACH AREA. IF THERE ARE NO NEEDS, PROVIDE A NARRATIVE OF CURRENT STRENGTHS		
Insurance Benefits	☐ CSHCN Services Program Reapplication date:	
	☐ CHIP:	
	☐ Private Insurance:	
	☐ Other (please specify):	
	☐ None	

Medications ☐ None	
Nutrition ☐ None	
Dental ☐ None	
Supplies: Medical/Adaptive Equipment/Other ☐ None	
Immunizations Current? ☐ Yes ☐ No	

CLIENT - HEALTH CARE PROVIDERS			
	PROVIDER NAME	**ADDRESS/PHONE**	**NEXT APPOINTMENT**
PCP/Medical Home Date of last well-child checkup:			
Physicians/Specialists			
Hospital			
Dentist Date of last dental checkup:			
Pharmacy			
DME/Medical and Adaptive Equipment			
Home Health Provider/Nursing			
Other			

CLIENT - DEVELOPMENTAL/REHABILITATIVE/SOCIAL	
DESCRIBE ANY NEEDS OR CONCERNS IN EACH AREA. IF THERE ARE NONE, PROVIDE A NARRATIVE OF CURRENT STRENGTHS	
What's important to me?	
What can help support me?	
Self-Help Skills (Feeding, dressing, other activities of daily living)	
Motor Skills	
Hearing	
Vision	
Speech/Language/ Communication	
Mental and Behavioral Health/ Peer Relationships	

Physical/Occupational Therapy	

CLIENT - EDUCATION			
DESCRIBE ANY NEEDS OR CONCERNS IN EACH AREA. IF THERE ARE NONE, PROVIDE A NARRATIVE OF CURRENT STRENGTHS			
School:	**Grade:**	**Special Education?** ☐Yes ☐No	**If not enrolled in Special Ed, is referral needed?** ☐ Yes ☐ No
Date of Last ARD: Comments:			**Date of Next ARD:**
Concerns at school			
Favorite school and/or after school activities (subjects, extracurricular activities, clubs)			

CLIENT – TRANSITION	
DESCRIBE ANY NEEDS OR CONCERNS IN EACH AREA. IF THERE ARE NONE, PROVIDE A NARRATIVE OF CURRENT STRENGTHS	
Educational Needs (Assist with IEP development, attend ARD meetings, vocational training, post-secondary planning)	
Preparing for Employment (Job coaching, supported employment)	

Preparing for Independent Living (Discuss/develop plans for accessing Medicaid programs, transportation, housing)	
Preparing for Medical Needs as an Adult (Find adult providers, develop health care transition plan, prepare medical summary)	
Preparing for Financial Needs (SSI/SSDI)	
Preparing for Legal Needs (Guardianship, alternatives to guardianship)	

CLIENT – PERMANENCY PLANNING	
Please describe any other needs or concerns that would prevent the client from having a permanent, long-term living arrangement in a family within the community:	

CLIENT AND FAMILY - OTHER AGENCY INVOLVEMENT				
AGENCY/PROGRAM	**CLIENT/FAMILY MEMBER**	**RECEIVING/REFERRED/ APPLIED/WAITING**	**CONTACT PERSON**	**PHONE NUMBER**
☐ CHIP				

☐ Medicaid				
☐ Medicaid Waiver Programs				
☐ ECI				
☐ Local Intellectual & Developmental Disability Authority (formerly MHMR)				
☐ DARS				
☐ DADS				
☐ WIC				
☐ SNAP, TANF				
☐ OAG Child Support Division				
☐ Protective Services				
☐ SSI/SSDI				
☐ Other Agencies:				

FAMILY MEMBERS - HEALTH STATUS	
DESCRIBE ANY NEEDS OR CONCERNS IN EACH AREA.	
Medical	
Dental	
Other Health Concerns	

FAMILY (All Household Members)	
DESCRIBE ANY NEEDS OR CONCERNS IN EACH AREA.	
Education	
Employment	

Utilities/Food	
Financial Concerns	
Housing Concerns (Conditions, repairs needed, rent payment, plan for power outage, safety/environmental issues)	
Accessibility Concerns (home modifications)	
Emergency/Disaster Planning CSHCN plan form discussed and given to parent/guardian/client? ☐ Yes ☐ No	
Transportation (Medical Transportation Services, Personal transportation /safety/reliability/access)	
Legal (Child support, other)	
Community/Family Support Systems (Marital, social, community support, cultural issues, communications barriers, other)	
Cultural Issues	
Childcare	
Respite Care	
Mental/Behavioral Health	
Family Violence (Current or History)	

Substance Abuse (Current or History)	
Other Concerns	

Other Comments:

CASE MANAGER SIGNATURE: (include credentials)	**DATE:**
CASE MANAGER PRINTED NAME:	