CSHCN Program

WV CSHCN Screener Nursing Notes

TEAM: ___________________________________

Instructions: This form will be completed in conjunction with the WV CSHCN Screener to Capture medical information identified by the Eligibility Unit Registered Nurses' assessment.

DOB: ______________________

CLIENT NAME:		**CSHCN ID:**	

Physical **special health care need(s) Identified**	**ICD-10 Code**	**Treating Physician Name**

☐ Medical foods	
☐ 100% enteral food	

Additional (emotional, behavioral, mental, acute) Special health care needs	**ICD-10 Code**	**Treating Physician Name**

Durable Medical Equipment:	

ELIGIBILITY DETERMINATION	**Date of eligibility determination:**
☐ **Enrolled** ☐ **Tier 1 (Status 7)** ☐ **Tier 2 (Status 5)** ☐ **Tier 3 (Status 5)** ☐ **Denied** ☐ **Closed**	
☐ **Medicaid** ☐ **MCO** ☐ **Aetna** ☐ **THP** ☐ **UniCare** ☐ **CHIPS** ☐ **Waiver** ☐ **CDCSP** ☐ **Straight Med** ☐ **Private Ins.**	
☐ **Foster Care** ☐ **Adopted** ☐ **Subsidy** ☐ **FACTS 5-Medical Screens**	
☐ **NAS** ☐ **HEP-C** ☐ **HEP-B** ☐ **LEAD** ☐ **COVID-19** ☐ **Well-Child Visit – Date:** ☐ **Dental** ☐ **Vision**	

PCP:
Additional notes/comments

Form Completed by **Date**	**Form Reviewed By & Enrollment Completed by** **Date**

FOR OFFICE USE ONLY - CSHCN - 08/2021