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|  | MISSOURI DEPARTMENT OF SOCIAL SERVICES  CHILDREN’S DIVISION  **CHILD WITH SPECIAL NEEDS VERIFICATION FORM** | | | |
| **SECTION A. CHILD’S INFORMATION**  **This form is provided to collect information that defines or verifies a child with special needs. This form does not prohibit a medical professional from submitting a letter on professional letterhead.** | | | | |
| CHILD’S NAME | | CHILD’S DATE OF BIRTH | | DCN |
| **SECTION B. CHILD WITH SPECIAL NEEDS EXPLANATION (TO BE COMPLETED BY THE ATTENDING MEDICAL PROFESSIONAL, to include the child’s physician, psychologist, psychiatrist, licensed clinical social worker, licensed professional counselor, nurse practitioner, or physician’s assistant.)** | | | | |
|  | | | | |
| EXPLAIN THE MEDICAL CONDITION OF THE CHILD WITH SPECIAL NEEDS.  If the child is not functioning at his/her chronological age, at what age is the child functioning?   |  | | --- | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | | | | | |
| SIGNATURE OF MEDICAL PROFESSIONAL | | | DATE | |
| PRINT NAME OF MEDICAL PROFESSIONAL | | | PHONE NUMBER | |