



State of Vermont
Department of Health
 Children with Special Health Needs
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HealthVermont.gov

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Agency of Human Services

CHILDREN’S PERSONAL CARE SERVICES DIAGNOSIS VERIFICATION FORM

MUST BE SIGNED BY CHILD’S PHYSICIAN, PSYCHOLOGIST OR OTHER LICENSED CLINICIAN, NURSE PRACTITIONER, PHYSICIANS’ ASSISTANT OR PSYCHIATRIST

Children’s Personal Care Services requires that the applicant be diagnosed with a disability and/or health condition that *significantly* impacts the child’s ability to perform self-care skills at age appropriate level in order for the application to be considered.

Child’s Name:	Unique Identifier/Medicaid ID:	Date of Birth:
Mailing Address:	Parent/Guardian’s Name:	Telephone Number:

TO BE COMPLETED BY CLINICAL PERSONNEL ONLY:

Provider & Practice Name:	Address:	Medicaid Provider #:
<input type="checkbox"/> Physician <input type="checkbox"/> Physician’s Assistant <input type="checkbox"/> Nurse practitioner <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist <input type="checkbox"/> Other: (specify)		<input type="checkbox"/> N/A Telephone Number:
List Current Confirmed Diagnosis(es), Diagnosing Clinician and ICD-10 Code:		
Diagnosis /Clinician	ICD10	
Diagnosis /Clinician	ICD10	
Diagnosis /Clinician	ICD10	

I verify that this child has been diagnosed with this/ these disability(ies) and/or health condition(s) by myself or other clinical professionals qualified to make such diagnosis.

 Signature, Credentials

 Date

Please fax completed form to Children’s Personal Care at 802-863-6344