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## DEVELOPMENTAL DISABILITIES ANNUAL ELIGIBILITY UPDATE

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- Step 1. Fill out your child's name, date of birth, Medicaid number, and current contact information.  
Step 2. Check and explain any changes in your child's medical, developmental or social status within the last year.  
Step 3. Sign this form at the bottom and return to the ICDE in the envelope provided, **even if there are no changes.**

**If this form is not signed and returned within 30 days, your child's developmental disability services may lapse at the end of your child's current plan year.**

Child's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Medicaid Number \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**In the past year, has your child experienced any of the following? If so, please ✓ the box.**

### Medical

- Changes to current diagnosis - medical, mental health, developmental (i.e., addition or removal of a diagnosis)
- Developed a medical, mental health, or developmental condition that requires continued treatment
- Significant changes to their medications (e.g., addition or removal of medication for medical or mental health issues)

Please explain any changes: \_\_\_\_\_

- No changes in this area

### Behavior/Development

- Increase in severe aggression, self-injurious or other dangerous behavior that endangered the safety of your child or others
- Significant changes in your child's problem behaviors
- Significant changes in your child's functional skills or development

Please explain any changes: \_\_\_\_\_

- No changes in this area

### Social

- |  |   |
|--|---|
| <input type="checkbox"/> Recent death of someone close   | <input type="checkbox"/> Custody/placement issues           |
| <input type="checkbox"/> Relapse/decompensation          | <input type="checkbox"/> Parent conflict/separation/divorce |
| <input type="checkbox"/> Physical/sexual/emotional abuse | <input type="checkbox"/> Change in living situation         |
| <input type="checkbox"/> School/work problems            | <input type="checkbox"/> Other (please describe)            |

Please explain any changes: \_\_\_\_\_

- No changes in this area

- Please check this box if you would like to request that a full SIB-R be completed with your child by the ICDE.

X \_\_\_\_\_

Parent/Legal Guardian Signature

\_\_\_\_\_

Date

**PLEASE RETURN THIS FORM USING THE ENCLOSED ENVELOPE**  
(Region \_\_\_\_\_ Idaho Center for Disabilities Evaluation)(address)(city, state, zip)(phone)



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**