

## Screening Tool for Federal Benefits

Child Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Client ID: \_\_\_\_\_

Case Head: \_\_\_\_\_ FACTS #: \_\_\_\_\_ Date Completed: \_\_\_\_\_

CWCMP: \_\_\_\_\_ Case Manager: \_\_\_\_\_

DCF IV-E Specialist: \_\_\_\_\_ Initial Screen ☐ Bi-Annual Screen ☐

### Screening Questions

#### *Social Security Death Benefits, Railroad, Veterans Affairs, and Retirement Benefits*

| #  | Question  | Yes                      | No                       | Unk                      |
|----|---|--------------------------|--------------------------|--------------------------|
| 1. | Have the biological and/or adoptive parents indicated that the child or the child's biological and/or adoptive parent is receiving Supplemental Social Security Income or other federal benefits? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Are any of the child's biological or adoptive parents disabled?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Are any of the child's biological or adoptive parents deceased?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Have any of the child's biological or adoptive parents ever been employed by the railroad?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Have any of the child's biological or adoptive parents ever been a service member in any branch of the U.S. Military?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If any of the above are answered yes, is this child already receiving a federal benefit as a result? Yes ☐ No ☐

If yes, which benefit(s): \_\_\_\_\_  
\_\_\_\_\_

If any of the above are answered yes, please send this completed tool to the below mailbox. If benefits are not already established, the Kansas Department for Children and Families will apply for benefits on behalf of the child and determination will be sent to Child Welfare Case Management Provider upon receipt.

Kansas City- [DCF.WyFCLiaison@ks.gov](mailto:DCF.WyFCLiaison@ks.gov)

Atchison- [DCF.AtFCLiaison@ks.gov](mailto:DCF.AtFCLiaison@ks.gov)

Wichita- [DCF.WICLiaison DL@ks.gov](mailto:DCF.WICLiaison_DL@ks.gov)

Northwest and Southwest- [DCF.WERLiaison@ks.gov](mailto:DCF.WERLiaison@ks.gov)

Northeast- [DCF.SNLiaison@ks.gov](mailto:DCF.SNLiaison@ks.gov)

Douglas- [DCF.DGFCLiaison@ks.gov](mailto:DCF.DGFCLiaison@ks.gov)

Leavenworth- [DCF.LVFCLiaison@ks.gov](mailto:DCF.LVFCLiaison@ks.gov)

Johnson- [DCF.JOLiaison@ks.gov](mailto:DCF.JOLiaison@ks.gov)

Southeast- [dcf.sefcado@ks.gov](mailto:dcf.sefcado@ks.gov)

## ***Child Social Security Income***

| #   | Question   | Yes                      | No                       | Unk                      |
|-----|--|--------------------------|--------------------------|--------------------------|
| 1.  | Does the child have a disorder considered a presumptive disability?<br><a href="http://www.SSA.gov/compassionateallowances">Compassionate Allowance Conditions</a> <a href="http://www.SSA.gov/compassionateallowances">www.SSA.gov/compassionateallowances</a>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.  | Has the child ever met criteria for Serious Emotional Disturbance (SED) by a Community Mental Health Center?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.  | Does the child have a history of psychiatric in-patient hospitalization of greater than one month at a time?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.  | Is the child currently on the waitlist for a psychiatric residential treatment facility?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5.  | Does the child have a history of less intensive mental health treatment? Such as acute hospitalization or Qualified Residential Treatment Programs (QRTP). <i>Exclude general therapy such as family therapy or individual therapy without presence of additional criteria indicating higher need.</i>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6.  | Is the child currently on a psychotropic medication?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7.  | Does the child have serious physical or mental health conditions which limits their ability to do the following in an age-appropriate way:<br>* Attend to and complete tasks,<br>* Interact and relate to others,<br>* Move and manipulate objects,<br>* Care for self, such as toileting and bathing,<br>* Acquire and use information (IQ of 70 or below, learning disabilities, severe speech problems) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8.  | Has the child been hospitalized or require ongoing medical treatment for a medical disability that has lasted or can be expected to last 12 months or result in death?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.  | Does the child have a cognitive disability or traumatic brain injury?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | Does the child require adaptations or assistive devices to function in daily life, such as hearing aids, orthopedic devices, and alternative communication devices?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | Does child receive special services, such as OT, PT, or other specialized services?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. | Does the child have an Individualized Education Plan (IEP), 504 plan, have a pending IEP, or is being assessed for these services?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. | Does the child have a functional impairment in the school setting? This can include chronic absenteeism due to a health condition or behavioral problem.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. | Is there any other reason the child may be eligible for disability benefits? If so, explain:   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If any of the above Child Social Security Income questions are answered yes, is this child already receiving Social Security as a result?

Yes ☐ No ☐

If any of the above are answered yes and benefits are not already established, please send this completed tool along with SSI application to **Kansas Legal Services**.

Please copy the regional Foster Care Liaison on referral:

**Kansas City-** [DCF.WyFCLiaison@ks.gov](mailto:DCF.WyFCLiaison@ks.gov)

**Douglas-** [DCF.DGFCLiaison@ks.gov](mailto:DCF.DGFCLiaison@ks.gov)

**Atchison-** [DCF.AtFCLiaison@ks.gov](mailto:DCF.AtFCLiaison@ks.gov)

**Leavenworth-** [DCF.LVFCLiaison@ks.gov](mailto:DCF.LVFCLiaison@ks.gov)

**Wichita-** [DCF.WICLiaison DL@ks.gov](mailto:DCF.WICLiaison_DL@ks.gov)

**Johnson-** [DCF.JOLiaison@ks.gov](mailto:DCF.JOLiaison@ks.gov)

**Northwest and Southwest-** [DCF.WERLiaison@ks.gov](mailto:DCF.WERLiaison@ks.gov)

**Northeast-** [DCF.SNLiaison@ks.gov](mailto:DCF.SNLiaison@ks.gov)

**Southeast-** [dcf.sefcado@ks.gov](mailto:dcf.sefcado@ks.gov)

Comments:

---

---

---

---

---

---

Name of person completing form: \_\_\_\_\_ Date \_\_\_\_\_

