

## CSHCS CLIENT SERVICE NEEDS QUESTIONNAIRE

Michigan Department of Health and Human Services

Children's Special Health Care Services

P.O. Box 30734

Lansing, MI 48909-8234

Child/Client Name	Date of Interview	County Health Department
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### Please describe the following:

1. Child/Client current medical status, treatment regime, pending surgery, etc.:	
2. Daily pattern of care for Child/Client (equipment, prosthesis, nutrition, activity, sleep, etc.):	
3. Impact of Child/Client special needs on family/siblings:	
4. How does the Child/Client feel about their special needs:	
5. Child/Client relationship with peers and siblings:	
6. Family's support system (friends, church, babysitters, respite):	
7. Recreational activities enjoyed by Child/Client and Family:	
8. Family's satisfaction with educational programs and employment status:	
9. Financial impact of Child/Client diagnosis on family:	
10. Other family concerns:	
LHD SIGNATURE	Date Signed

The Michigan Department of Health and Human Services does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

**AUTHORITY:** Title V of the Social Security Act

**COMPLETION:** Is voluntary