

Parent Supplemental Statement

Optional Support Document – May Be Included with Initial Application or Appeal
Delete all red instructional text before submitting.

Child's Name: [Insert child's full legal name]

Date of Birth: [Insert DOB]

Date Submitted: [Insert submission date]

To Whom It May Concern,

This statement provides additional clarification regarding my child's daily functional needs, supervision requirements, medical management, and prescribed treatment intensity.

Appeal Clarification – Delete if Not Appealing

If submitting with an appeal, complete the paragraph below. Otherwise, delete this entire section.

This statement is submitted in response to the denial dated [Insert denial date]. The denial indicated that [Briefly summarize reason stated in denial letter]. The information below is provided to clarify areas that may not have been fully reflected in the initial review and to further demonstrate the intensity of care and supervision required.

Overview of Diagnoses and Functional Impact

My child is diagnosed with:

[List diagnoses here.]

These conditions significantly impact daily functioning in areas such as communication, adaptive skills, mobility, emotional regulation, executive functioning, and/or medical stability.

Delete any areas listed that are not applicable.

Daily Functional and Adaptive Needs

Growing Together: Neurodiversity at Home | growingtogetherathome.com

Educational Resource – Not Legal or Medical Advice

My child requires assistance with activities of daily living, including [list applicable areas such as dressing, hygiene, toileting, feeding, mobility, task sequencing, etc.].

Provide specific examples. Be concrete rather than general.

Example: “Requires full assistance with dressing due to sensory intolerance and inability to sequence multi-step tasks.”

Without structured support and supervision, my child is unable to safely or independently complete age-appropriate daily tasks.

Medical Management at Home

My child requires ongoing medical management within the home setting, which includes:

- Medication administration [insert frequency and method of administration]
- Weekly medication organization and monitoring for side effects
- Monitoring for behavioral or medical instability
- [Add other relevant supports such as seizure monitoring, feeding tube care, orthotic management, blood sugar monitoring, etc.]

For example [delete if not applicable]:

- Requires medication administration at least [X] times daily
- Requires orthotic device (AFO) monitoring and frequent follow-up for adjustments due to skin irritation, tolerance issues, and growth-related fit changes
- Requires coordination of multiple specialty providers

These tasks require consistent adult oversight and intervention beyond typical age-appropriate supervision.

Supervision and Safety Requirements

My child requires ongoing supervision due to safety concerns that may include impulsivity, elopement risk, self-injury, aggression, lack of danger awareness, or medical instability.

[Describe level of supervision required: continuous, line-of-sight, frequent redirection, medical monitoring, etc.]

Without this level of supervision and intervention, there is a significant risk of injury, behavioral escalation, or medical decompensation.

Therapy and Treatment Intensity

My child's prescribed treatment plan includes medically necessary therapies and specialty services such as occupational therapy, physical therapy, speech therapy, behavioral therapy (including ABA when applicable), psychological or psychiatric services, medication management, and specialty medical follow-up as clinically indicated.

The recommended intensity of services includes:

[Insert prescribed therapy frequencies here — Example: Occupational Therapy 2x/week, Speech Therapy 2x/week, Behavioral Therapy 5 days/week, Psychiatric follow-up monthly.]

If services are not currently being received at full recommended intensity, explain why (waiting list, provider availability, cost barriers, insurance limits, scheduling constraints). The prescribed level of care remains medically necessary regardless of current service access.

In addition to direct therapy sessions, my child's treatment plan requires frequent transportation to medical and therapy appointments. These appointments often occur multiple times per week and require direct parent supervision and coordination. This reflects the ongoing level of care necessary to maintain stability and prevent regression.

These services and the intensity of care are medically necessary to support safety, functional development, and medical stability.

Educational Impact [Delete if Not Applicable]

Due to the frequency of medical appointments, therapy schedules, behavioral regulation needs, and/or medical instability, traditional school attendance has not been feasible.

Describe impact. Example: "We have elected to homeschool in order to accommodate medical appointments and provide necessary supervision and regulation support." Or, describe the impact on traditional school.

Educational needs further reflect the level of functional impairment and supervision required.

Institutional Level of Care Clarification

Due to the severity and intensity of these needs, my child requires a level of care consistent with services typically provided in an institutional setting, including hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities.

Katie Beckett Medicaid allows these services to be provided safely within the home rather than requiring institutional placement.

Thank you for your time and consideration.

Sincerely,

[Parent/Guardian Name]

Signature: _____

Date: _____