

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

State _____ FY _____		Age Groups							
		Total	<1	1 - 2 *	3 - 5	6 - 9	10 - 14	15 - 18	19-20
1. Total Individuals Eligible for EPSDT	CN								
	MN								
	Total								
2a. State Periodicity Schedule									
2b. Number of Years in Age Group			1	2	3	4	5	4	2
2c. Annualized State Periodicity Schedule									
3a. Total Months of Eligibility	CN								
	MN								
	Total								
3b. Average Period of Eligibility	CN								
	MN								
	Total								
4. Expected Number of Screenings per Eligible	CN								
	MN								
	Total								
5. Expected Number of Screenings	CN								
	MN								
	Total								
6. Total Screens Received	CN								
	MN								
	Total								
7. Screening Ratio	CN								
	MN								
	Total								

* Includes 12-month visit

Note: "CN" = Categorically Needy, "MN" = Medically Needy

OMB control number: 0938-0354

State _____ FY _____		Age Groups							
		Total	<1	1 - 2 *	3 - 5	6 - 9	10 - 14	15-18	19-20
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN								
	MN								
	Total								
9. Total Eligibles Receiving at Least One Initial or Periodic Screen	CN								
	MN								
	Total								
10. PARTICIPANT RATIO	CN								
	MN								
	Total								
11. Total Eligibles Referred for Corrective Treatment	CN								
	MN								
	Total								
12a. Total Eligibles Receiving Any Dental Services	CN								
	MN								
	Total								
12b. Total Eligibles Receiving Preventive Dental Services	CN								
	MN								
	Total								
12c. Total Eligibles Receiving Dental Treatment Services	CN								
	MN								
	Total								
13. Total Eligibles Enrolled in Managed Care	CN								
	MN								
	Total								
14. Total number of Screening Blood Lead Tests	CN								
	MN								
	Total								

* Includes 12-month visit

Note: "CN" = Categorically Needy, "MN" = Medically Needy

|