DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM HCFA-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

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