Pediatric Level of Care Determination Form

Instructions: Parent(s)/guardian(s) must complete **Part A** of this form. Medical provider(s) must complete **Parts B and C** of this form. All remaining information will be completed by a Quality Improvement Organization. Please print clearly and complete all sections. Signatures **must** be dated within thirty (30) days of application. Once completed, please return this form to the DC Department of Health Care Finance.

- **By Mail:**
  Department of Health Care Finance
  Division of Children's Health Services
  Attn: TEFRA/Katie Beckett
  441 4th Street NW, Suite 900S
  Washington, DC 20001
- **By Email at HealthCheck@dc.gov**

Level of Care Determination: ☐ Nursing Facility	☐ Hospital	☐ IC/ID Facility

Reason for Request for TEFRA/Katie Beckett Coverage Group:
☐ Initial Assessment for TEFRA/Katie Beckett Coverage Group ☐ Reassessment

Part A- Identifying Information

Date of Request:	/ /

Last Name:	First Name:	M.I.:
Social Security Number: ____ - ___ - _____	Medicaid # (If Applicable):	
Date of Birth ____ / ____ / _____	Gender: Male ☐ Female ☐	
Permanent Address (include name of facility, if applicable) _____ _____	**Present Location of Applicant** (if different from permanent address) _____ _____	
Phone (____) ____ - _____	**Phone** (____) ____ - _____	
Does child attend school? ☐ Yes ☐ No		

Name of Parent/ Guardian 1:	Relationship:
Last:	First:
Email Address:	
Name of Parent/ Guardian 2	Relationship
Last	First
Email Address:	

Part B- Evaluation of Nursing Care Needed (check appropriate box only)

Nutrition	Bowel	Cardiopulmonary Status	Mobility	Behavioral Status
☐ Regular ☐ Diabetic Shots ☐ Formula-Special ☐ Tube feeding ☐ N/G-tube/ G-tube ☐ Slow Feeder ☐ FIT or Premature ☐ Hyperal ☐ IV Use ☐ Medications/ GT Meds	☐ Age Dependent Incontinence ☐ Incontinent – Age > 3 ☐ Colostomy ☐ Continent ☐ Other _____	☐ Monitoring ☐ CPAP/Bi-PAP ☐ CP Monitor ☐ Pulse Ox ☐ Vital Signs > 2/day ☐ Therapy ☐ Oxygen ☐ Home Vent ☐ Trach ☐ Nebulizer Tx ☐ Suctioning ☐ Chest- Physical Tx ☐ Room Air	☐ Prosthesis ☐ Splints ☐ Unable to ambulate > 18 months old ☐ Wheel Chair ☐ Normal	☐ Agitated ☐ Cooperative ☐ Alert ☐ Developmental Delay ☐ Intellectual Disability ☐ Behavioral Problems (please describe, if checked) ☐ Suicidal ☐ Hostile
Integument System	**Urogenital**	**Surgery**	**Therapy/ Visits**	**Neurological Status**
☐ Burn Care ☐ Sterile Dressings ☐ Decubiti ☐ Bedridden ☐ Eczema-severe☐ Normal	☐ Dialysis in home ☐ Ostomy ☐ Incontinent – Age > 3 ☐ Catheterization ☐ Continent	☐ Level I (5 or > surgeries ☐ Level II (<5 surgeries) ☐ None	Daycare Services ☐ High Tech – 4 or more times per week ☐ Low Tech – 3 or less times per week or MD visits > 4 times per month ☐ None Other Therapy/ Visits ☐ 5 days per week ☐ Less than 5 days per week	☐ Deaf ☐ Blind ☐ Seizures ☐ Neurological Deficits ☐ Paralysis ☐ Normal
Remarks:				
If additional supporting documents are included, please list them here:				

Name of Person Completing Form:	**Title:**
Signature of Person Completing Form:	**Date:**

Part C – Must be completed by a Physician, Physician Assistant, or Nurse Practitioner Responsible for Patient Care

I certify that the information presented above appropriately reflects the patient's functional status. I certify that the patient's condition ☐ has lasted or ☐ is expected to last for a continuous period of not less than twelve (12) months, or ☐ is expected to result in death. I have been providing care to the patient for ____ months, ____ years. The patient's condition ☐ could ☐ could not be managed by provision of ☐ Community Care or ☐ Home Health Services.

Name: Address:	**Please check appropriate box:** ☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner
Phone: (____) ____ - _____	NPI*
Signature:	Date:

* Physician Assistants should include their supervising physician's NPI number.

Part D- To be completed by the Quality Improvement Organization

Level of Care:	Certification Period:
Authorized Signature:	Date:
Comments: _____ __ _____ __	