Government of the District of Columbia
Department of Health Care Finance

Pediatric Level of Care Determination Form

Instructions: Please print clearly and complete all sections. Signatures must be dated within thirty (30) days of application.

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
	Does child attend school? ☐ Yes ☐ No

Part A- Identifying Information

Date of Request ____ /____ /_____ Applicant Name _____
Last First M.I.

Social Security Number ____ - ___ - _____ Medicaid # (If Applicable) _____

Date of Birth ____ / ____ / _____ Gender _____

Permanent Address (include name of facility, if applicable)	**Present Location of Applicant** (if different from permanent address)
_____ _____	_____ _____
Phone (____) ____ - _____	**Phone** (____) ____ - _____

Name of Parent/ Guardian 1 _____ Relationship _____
Last First

Email Address: _____

Name of Parent/ Guardian 2 _____ Relationship _____
Last First

Email Address: _____

DHCF HCDMA SF004
Revised 05/05/11

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.

		Please check appropriate box:
Name	_____	☐ Physician
		☐ Physician Assistant
		☐ Nurse Practitioner
Address	_____	
	_____	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 _____

_____

Return this form as part of completed application packet to:

Department of Health Care Finance
Division of Long Term Care
Attn: TEFRA/Katie Beckett Coverage Group
441 4th Street NW, Suite 900S
Washington, DC 20001
(202) 442-5957