Level of care criteria are based on definitions and guidelines derived from the Federal regulations and are used to assist assessors in evaluating clinical information submitted.

PEDIATRIC

NURSING FACILITY LEVEL OF CARE

Summary:

1. Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or Other health-related services *ordinarily provided in an institution*. With respect to an individual who has a mental illness or mental retardation, nursing facility level of care services Are usually inappropriate unless that individual's mental health needs are secondary to needs associated with a more acute physical disorder.
2. The criteria set forth herein encompass both "skilled" and "intermediate" levels of care services.
3. A nursing facility level of care is indicated if the conditions of Column A are satisfied in addition to the conditions of Column B being satisfied. Conditions are derived from 42 C.F.R. 409.31 – 409.34.
4. Some examples of those cases which meet Nursing Facility Level of Care Criteria are as follows:
   a. Severely Medical Fragile Child as they will meet the criteria in Column A, 1, and I,2, b and possibly others under 2 depending on the individual child plus Column B.
   b. Child with Cystic Fibrosis if they are receiving oxygen 5-7 days a week intermittently or continuously and/or the child has to be hospitalized 3-4 times per year for Cystic Fibrosis exacerbations which will meet the criteria in Column A, 1, and I, 2, b, j and Column B.
   c. Child with Osteogensis Imperfecta Type 2 and 3. A child with Type 2 has the most severe form which is frequently lethal and the child has numerous fractures with severe bone deformity. Type 3 has bones that fracture easily and possible respiratory problems. This child will meet the criteria in Column A, 1, and 2, b, k and II (possibly a-e) and Column B.
   d. Child who is medically unstable awaiting organ transplant and/or is in post-op period for one year post transplant. This child will meet the criteria in Column A,
   1, and I, 2, b, and possibly others under 2 depending on the individual child plus Column B. This child will meet hospital level of care while in hospital for transplant. Once the child is stable post transplant he/she no longer meets nursing facility level of care criteria.
   e. Children born at 26 weeks or less gestation. These children are at high risk of complications due to prematurity and are in the NICU at the beginning of life. These children would meet hospital level of care criteria while hospitalized and nursing facility level of care once discharged. The child will meet multiple criteria in Column A and B depending on the medical needs of the child and will initially be approved for only six months and then re-evaluated.
   f. Child with Hemophilia: who is receiving IV Factor 8 on a 2-3 times/month schedule; or who has documented antibodies to Factor 8 (high risk for bleeding); or who exhibits chronic joint syndrome or a head bleed which requires an aggressive rehabilitation program. The child will meet multiple criteria in Column A and
   B depending on the medical needs of the child.
   g. Child with Sickle Cell: who is receiving chronic transfusions of 1-2 per month; or is admitted to the hospital with acute chest syndrome 2 or more times per year; or who is in pain crisis requiring hospitalization 3 or more times per year; or who has had a stroke and is involved in an aggressive rehabilitation program The child will meet multiple criteria in Column A and B depending on the medical needs of the child.

Revised 1-06, 2/06

COLUMN A		**COLUMN B**
	II.	
1. The individual requires service which is so inherently complex that it can be safely and effectively performed only	2. The service is one of the following or similar and is required five days per	1. The service needed has been ordered by a

by, or under the supervision of,
technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, and speech pathologists or audiologists,

AND

In addition to the condition listed above, one of the following subparts of #2 must be met:

I.

2. The service is one of the following or similar and is required seven days per week:
   a. Overall management and evaluation of a care plan for an individual who is totally dependent in all activities of daily living
   b. Observation and assessment of an individual's changing condition because the documented instability of his or her medical condition is likely to result in complications, or because the documented instability of his or her mental condition is likely to result in suicidal or hostile behavior
   c. Intravenous or intramuscular injections or intravenous feeding
   d. Enterable feeding that comprises at least 26 per cent of daily calorie requirements and provides at least 501 milliliters of fluid per day
   e. Nasopharyngeal or tracheostomy aspiration
   f. Insertion and sterile irrigation or replacement of suprapubic catheters
   g. Application of dressings involving prescription medications and aseptic techniques
   h. Treatment of extensive Decubiti ulcers or other widespread skin disorder
   i. Heat treatments as part of active treatment which requires observation by nurses
   j. Initial phases of a regimen involving administration of medical gases
   k. Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment

OR

week:
   a. Ongoing assessment of rehabilitation needs and potential: services concurrent with the management of a patient care plan
   b. Therapeutic exercises and activities performed by PT or OT
   c. Gait evaluation and training to restore function to a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality
   d. Range of motion exercises which are part of active treatment of a specific condition which has resulted in a loss of, or restriction of mobility
   e. Maintenance therapy when specialized knowledge and judgment is needed to design a program based on initial evaluation
   f. Ultrasound, short-wave, and microwave therapy treatment
   g. Hot pack, hydro collator, infrared treatments, paraffin baths, and whirlpool treatment when the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, etc. and specialized knowledge and judgment is required
   h. Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing

OR

III

2. The service is one of the following only if an additional special medical complication requires that it be performed or supervised by technical or professional personnel:
   a. Administration of routine medications, eye drops, and ointments.
   b. General maintenance care of colostomy or ileostomy
   c. Routine services to maintain satisfactory functioning of indwelling bladder catheters
   d. Changes of dressings for non-infected postoperative or chronic conditions
   e. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems
   f. Routine care of incontinent individuals, including use of diapers and protective sheets
   g. General maintenance care (e.g. in connections with a

physician.

2. The service will be furnished either directly by, or under the supervision of, appropriately licensed personnel.
3. *The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.*

	plaster cast) h. Use of heat as a palliative and comfort measure (e.g. whirlpool and hydrocollator) i. Routine administration of medical gases after a regimen of therapy has been established j. Assistance in dressing, eating, and toileting k. Periodic turning and positioning of patients. l. General supervision of exercises that were taught to the individual and can be safely performed by the individual including the actual carrying out of maintenance programs	

INTERMEDIATE CARE FACILITY (ICF/MR) LEVEL OF CARE

Summary:

1. ICF/MR level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with mental retardation or related conditions.
2. An ICF/MR level of care is generally indicated if one condition of Column A is satisfied in addition to the conditions Column B and Column C being satisfied. Conditions derived from 42 C.F.R. 440.150, 435.1009, and 483.440(a).
3. Column B refers to "an aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services." These active treatment services, as defined in 42 C.F.R. 483.440, provide aggressive, consistent monitoring, supervision and/or assistance as defined in the plan of care to address the specific medical conditions, developmental and behavioral needs, and/or functional limitations identified in the comprehensive functional assessment. This comprehensive functional assessment must be age appropriate.
4. The following conditions meet ICF/MR institutional level of care criteria, as these individuals would be institutionalized regardless of ability to participate in an aggressive program of specialized and generic training, treatment, health services, and related services as outlined in Column B:
   - Those children with an IQ of 50 or below (moderate to profound mental retardation) or
   - Those children who meet the criteria for Autism, Autism-Spectrum, Asperger's, Pervasive Developmental Disorder, Developmental Delay, Mental Retardation, Down's Syndrome, and any other Developmental Disability as evidenced by:
     i. a score on a standardized adaptive functioning tool of 2 standard deviations below the norm in three or more of any of the following behavior domains: self care skills, understanding and use of verbal and nonverbal language learning in communication with others, mobility, self-direction, and age-appropriate ability to live without extraordinary assistance or an overall standard score < 70, or
     ii. if their age equivalency composite score is less than 50% of their chronological age, and/or
     iii. the child has a Childhood Autism Rating Scale (CARS) score of above 37, a Gilliam Autism Rating Scale (GARS) of 121 or greater, or any other equivalent standardized assessment tool which indicate severe autism.

COLUMN A (Diagnosis)	COLUMN B (Plan of Care)	COLUMN C (Functional Need)
1. The individual has mental retardation. OR 2. The individual has a severe chronic disability attributable to cerebral palsy or epilepsy. OR 3. The individual has a condition, *other than mental illness*, (i.e. Autism, Autism-spectrum, Asperger's, Pervasive Developmental Disorder, Down's Syndrome or Developmental Delay) which is found to be closely related to mental retardation because it is likely to last indefinitely, and requires similar treatment and services. AND 4. The impairment for those conditions outlined above constitutes an impairment of general intellectual functioning, and results in substantial limitations in three or more of the following functional limitations: • Self-care skills such as feeding, toileting, dressing and bathing; • Understanding and use of verbal and nonverbal language learning in communication with others; • Mobility; • Self-direction in managing one's social and personal life and the ability to make decisions necessary to protect one's self as per age-appropriate ability; and/or • Age-appropriate ability to live without extraordinary assistance.	On a continuous basis, the individual requires aggressive consistent implementation of a program of specialized and generic training, treatment, health services, and related services which is directed towards- a. The acquisition of the skills necessary for the individual to function with as much self-determination and independence as possible; and b. The prevention of further decline of the current functional status or loss of current optimal functional status. This is evidenced in the Plan of Care by the individual's participation (at least five (5) days a week) in interventions which are required to correct or ameliorate the conditions/diagnosis; and are compatible with acceptable professional practices in light of the condition(s) at the time of treatment. Active treatment does not include: • interventions that address age-appropriate limitations; or • general supervision of children whose age is such that supervision is required by all children of the same age or • physical assistance for persons who are unable to physically perform tasks but who understand the process needed to do them	1. The services have been ordered by a licensed physician. AND 2. The services will be furnished either directly by, or under the supervision of, appropriately qualified providers (see definitions): AND 3. The services, as a practical matter, would have ordinarily been provided in an ICF-MR, in the absence of community services. *Revised 3/3/06*

HOSPITAL LEVEL OF CARE

Summary:

1. Hospital level of care is appropriate for individuals who continuously require the type of care ordinarily provided in an institution for the care and treatment of inpatients with disorders other than mental diseases.
2. A hospital level of care is indicated if the conditions of Column A, Column B, and Column C are satisfied. Conditions derived from 42 C.F.R 440.10.

COLUMN A	COLUMN B	COLUMN C
1. The individual has a condition for which room, board, and professional services furnished under the direction of a physician or dentist is expected to be medically necessary for a period of 48 hours or longer. 2. The professional services needed are something other than nursing facility and ICF/MR services.	The individual's condition meets inpatient level of care.	1. The service needed has been ordered by a physician or dentist. 2. The service will be furnished either directly by, or under the supervision of, a physician or dentist. 3. The service is ordinarily furnished, as a practical matter, in an appropriately licensed institution for the care and treatment of patients with disorders other than mental diseases.

NURSING FACILITY LEVEL OF CARE — *COLUMN A*	**EXPLANATIONS**
	42 CFR 409.31-409.34 **I.**
1. The individual requires service which is so inherently complex that it can be safely and effectively performed only by, or under the supervision of, technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, and speech pathologists or audiologists. In addition to the condition listed above, one of the following subparts of #2 must be met: **I.**	1. Definition. As used in this section, skilled nursing and skilled rehabilitation services means services that: (1) Are ordered by a physician; (2) Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and (3) Are furnished directly by, or under the supervision of, such personnel.
2. The service is one of the following or similar and is required seven days per week:	2. Specific conditions for meeting level of care requirements. (1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.
2 a. Overall management and evaluation of a care plan for an individual who is totally dependent in all activities of daily living	2. a. Services that could qualify as either skilled nursing or skilled rehabilitation services--(1) Overall management and evaluation of care plan. (i) When overall management and evaluation of care plan constitute skilled services. The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. Those activities include the management of a plan involving a variety of personal care services only when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel. (ii) Example. An aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one

	service on the other. Since the nature of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled.
2. b. Observation and assessment of an individual's changing condition because the documented instability of his or her medical condition is likely to result in complications, or because the documented instability of his or her mental condition is likely to result in suicidal or hostile behavior.	2. b. Observation and assessment of the patient's changing condition-- (i) When observation and assessment constitute skilled services. Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or for additional medical procedures until his or her condition is stabilized. (ii) Examples. A patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures. Similarly, surgical patients transferred from a hospital to an SNF while in the complicated, unutilized postoperative period, for example, after hip prosthesis or cataract surgery, may need continued close skilled monitoring for postoperative complications and adverse reaction. Patients who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, may also require skilled observation and assessment by technical or professional personnel to ensure their safety or the safety of others, that is, to observe for indications of suicidal or *Contract #500-99-0009/0003 DynCorp Therapy PSC Page 204 of 1201 Deliverable # 25 – Dissemination of Educational Materials 30 November 2001TRP Compilation of National Part B Therapy Policy* hostile behavior. The need for services of this type must be documented by physicians' orders or nursing or therapy notes.
2. c. Intravenous or intramuscular injections or intravenous feeding	2. c. Services that qualify as skilled nursing services. (1) Intravenous or intramuscular injections and intravenous feeding.
2. d. Enteral feeding that comprises at least 26 per cent of daily calorie requirements and provides at least 501 milliliters of fluid per day	2. d. Enteral feeding that comprises at least 26 per cent of daily calorie requirements and provides at least 501 milliliters of fluid per day.
2. e. Nasopharyngeal or tracheostomy aspiration	2. e. Nasopharyngeal and tracheostomy aspiration;
2. f. Insertion and sterile irrigation or replacement of suprapubic catheters	2. f. Insertion and sterile irrigation and replacement of suprapubic catheters;
2. g. Application of dressings involving prescription medications and aseptic techniques	2. g. Application of dressings involving prescription medications and aseptic techniques;
2. h. Treatment of extensive decubitis ulcers or other widespread skin disorder	2. h. Treatment of extensive decubitus ulcers or other widespread skin disorder;
2. i. Heat treatments as part of active treatment which requires observation by nurses	2. i. Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient's progress;

2. j. Initial phases of a regimen involving administration of medical gases	2. j. Initial phases of a regimen involving administration of medical gases;
2. k. Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment	2. k. Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs.
OR	**EXPLANATIONS**
II.	**II.**
2. The service is one of the following or similar and is required five days per week:	2. To meet the daily basis requirement specified in Sec. 409.31(b)(1), the following frequency is required: - Skilled nursing services or skilled rehabilitation services must be needed and provided 7 days a week; or - As an exception, if skilled rehabilitation services are not available 7 days a week those services must be needed and provided at least 5 days a week. - A break of one or two days in the furnishing of rehabilitation services will not preclude coverage if discharge would not be practical for the one or two days during which, for instance, the physician has suspended the therapy sessions because the patient exhibited extreme fatigue.
2. a. Ongoing assessment of rehabilitation needs and potential concurrent with the management of a care plan	2. a. Services which would qualify as skilled rehabilitation services. (1) Ongoing assessment of rehabilitation needs and potential: Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders.
2. b. Therapeutic exercises and activities performed by PT or OT	2. b. Therapeutic exercises or activities: Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment.
2. c. Gait evaluation and training to restore function to a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality	2. c. Gait evaluation and training: Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality.
2. d. Range of motion exercises which are part of active treatment of a specific condition which has resulted in a loss of, or restriction of mobility	2. d. Range of motion exercises: Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored).
2. e. Maintenance therapy when specialized knowledge and judgment is needed to design a program based on initial evaluation	2. e. Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance

	program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance. For example, a patient with Parkinson's disease who has not been under a rehabilitation regimen may require the *Contract #500-99-0009/0003 DynCorp Therapy PSC Page 205 of 1201Deliverable # 25 – Dissemination of Educational Materials 30 November 2001 TRP Compilation of National Part B Therapy Policy* services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning.
2. f. Ultrasound, short-wave, and microwave therapy treatment	2. f. Ultrasound, short-wave, and microwave therapy treatment by a qualified physical therapist;
2. g. Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool treatment when the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, etc. and specialized knowledge and judgment is required	2. g. Hot pack, hydrocollator, infrared treatments, paraffin baths, and .whirlpool; Hot pack hydrocollator, infrared treatments, paraffin baths, and whirlpool in particular cases where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgment of a qualified physical therapist are required.
2. h. Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing **OR**	2. h. Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.
III. **2.** ***The service is one of the following only if an additional special medical complication requires that it be performed or supervised by technical or professional personnel:***	**EXPLANATIONS** III. 2. A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled (such as those listed in Sec. 409.33 (d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust

2. a. Administration of routine medications, eye drops, and ointments. 2. b. General maintenance care of colostomy or ileostomy 2. c. Routine services to maintain satisfactory functioning of indwelling bladder catheters 2. d. Changes of dressings for non-infected postoperative or chronic conditions 2. e. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems 2. f. Routine care of incontinent individuals, including use of diapers and protective sheets 2. g. General maintenance care (e.g. in connections with a plaster cast) 2. h. Use of heat as a palliative and comfort measure (e.g. whirlpool and hydrocollator) 2. i. Routine administration of medical gases after a regimen of therapy has been established 2. j. Assistance in dressing, eating, and toileting 2. k. Periodic turning and positioning of patients. 2. l. General supervision of exercises that were taught to the individual and can be safely performed by the individual including the actual carrying out of maintenance programs. General supervision of exercises that were taught to the individual and can be safely performed by the individual including the actual carrying out of maintenance programs, **OR**	traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes. 2. a. Administration of routine oral medications, eye drops, and ointments; 2. b. General maintenance care of colostomy and ileostomy; 2. c. Routine services to maintain satisfactory functioning of indwelling bladder catheters. 2. d. Changes of dressings for noninfected postoperative or chronic conditions; 2. e. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems; 3. f. Routine care of the incontinent patient, including use of diapers and protective sheets; 2. g. General maintenance care in connection with a plaster cast; 2. h. Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator; 2. i. Routine administration of medical gases after a regimen of therapy has been established. 2. j. Assistance in dressing, eating, and going to the toilet; 2. k. Periodic turning and positioning in bed; and 2. l. General supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious exercises to improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function; and assistive walking do not constitute skilled rehabilitation services.

NURSING FACILITY LEVEL OF CARE - *COLUMN B*	**EXPLANATIONS**
	IV. 42 CFR 409.31(a)(1) **I.**
1. The service needed has been ordered by a physician.	1. a. Definition. As used in this section, skilled nursing and skilled rehabilitation services means services that: (1) Are ordered by a physician;
	42 CFR 409.31(a.)(2.)(3)
2. The service will be furnished either directly by or under the supervision of appropriately licensed personnel.	2. Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and Are furnished directly by, or under the supervision of, such personnel.
	42 CFR 409.31(b) (3)
3. The service is ordinarily furnished, as a practical matter, on an impatient basis.	3. The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF, on an inpatient basis.
	42 CFR 409.35 General considerations. In making a ``practical matter'' determination, as required by Sec. 409.31(b)(3), consideration must be given to the patient's condition and to the availability and feasibility of using more economical alternative facilities and services. However, in making that determination, the availability of Medicare payment for those services may not be a factor. Example: The beneficiary can obtain daily physical therapy from a physical therapist in independent practice. However, Medicare pays only the appropriate portion (after deduction of applicable deductible and coinsurance amounts) of the first $500 of services furnished by such a practitioner in a year. This limitation on payment may not be a basis for finding that the needed care can only be provided in a SNF.

INTERMEDIATE CARE FACILITY (ICF/MR) LEVEL OF CARE — *COLUMN A*	**EXPLANATIONS** **42 CFR 435.1009**
I.	**I.**
1. The individual has mental retardation.	1. Institution for the mentally retarded or persons with related conditions means an institution (or distinct part of an institution) that: (a) Is primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions.
2. The individual has a severe chronic disability attributable to cerebral palsy or epilepsy.	2. Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions: It is attributable to cerebral palsy or epilepsy. ▪ It is manifested before the person reaches age 22. ▪ It is likely to continue indefinitely. ▪ It results in substantial functional limitations in three or more of the following areas of major life activity: (1) Self-care. (2) Understanding and use of language. (3) Learning. (4) Mobility. (5) Self-direction. (6) Capacity for independent living.
3. The individual has a condition, *other than mental illness*, which is found to be closely related to mental retardation because it is likely to last indefinitely, requires similar treatment and services, constitutes an impairment of general intellectual functioning, and results in substantial limitations in three or more of the following: self-care, understanding and use of language learning, mobility, self direction, and capacity for independent living.	3. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons. ▪ It is manifested before the person reaches age 22. ▪ It is likely to continue indefinitely. ▪ It results in substantial functional limitations in three or more of the following areas of major life activity: (1) Self-care. (2) Understanding and use of language. (3) Learning. (4) Mobility. (5) Self-direction.

	(6) Capacity for independent living.
INTERMEDIATE CARE FACILITY (ICF/MR) LEVEL OF CARE — *COLUMN B* 1. On a continuous basis, the individual requires aggressive consistent implementation of a program of specialized and generic training, treatment, health services, and related services which is directed towards— a. The acquisition of the skills necessary for the individual to function with as much self-determination and independence as possible; and b. The prevention of further decline of the current functional status or loss of current optimal functional status.	**EXPLANATIONS** **42 CFR 483.440** 1. Standard: Active treatment. (1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: a. The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and b. The prevention or deceleration of regression or loss of current optimal functional status.
INTERMEDIATE CARE FACILITY (ICF/MR) LEVEL OF CARE — *COLUMN C* 1. The service needed has been ordered by a physician. 2. The service will be furnished either directly by, or under the supervision of, appropriately licensed personnel.	**EXPLANATIONS** **42 CFR 483.460(a)(1-2)** 1. a. Standard: Physician services. (1) The facility must ensure the availability of physician services 24 hours a day. (2) The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires care ordinarily given on an inpatient basis. This plan must be integrated in the individual program plan. **42 CFR 483.430(a)(1-2)** 2. a. Standard: Qualified mental retardation professional. Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional who— (1) Has at least one year of experience working directly with persons with mental retardation or other developmental disabilities; and (2) Is one of the following: - A doctor of medicine or osteopathy. - A registered nurse.

3. The service required is ordinarily furnished, as a practical matter, on an inpatient basis.	- An individual who holds at least a bachelor's degree in a professional category specified in paragraph (b) (5) of this section. **42 CFR 483.460(a)(1-2)** 3. a. Standard: Physician services. (1) The facility must ensure the availability of physician services 24 hours a day. (2) The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires care ordinarily given on an inpatient basis. This plan must be integrated in the individual program plan.

HOSPITAL LEVEL OF CARE - *COLUMNS A, B, C*

HOSPITAL LEVEL OF CARE — *COLUMN A* 1. The individual has a condition for which room, board, and professional services furnished under the direction of a physician or dentist is expected to be medically necessary for a period of 48 hours or longer. 2. The professional services needed are something other than nursing facility and ICF/MR services.	**EXPLANATIONS** **42 CFR 440.2** 1. Receives room, board and professional services in the institution for a 24 hour period or longer. 2. Inpatient hospital services do not include SNF and ICF services furnished by a hospital with a swing-bed approval.
HOSPITAL LEVEL OF CARE — *COLUMN B* The individual's condition meets inpatient level of care.	
HOSPITAL LEVEL OF CARE — *COLUMN C* 4. The service needed has been ordered by a physician and dentist. 5. The service will be furnished either directly by, or under the supervision of, a physician or dentist. 6. The service is ordinarily furnished, as a practical matter, in an appropriately licensed institution for the care and treatment of patients with disorders other than mental diseases.	**EXPLANATIONS** **42 CFR 440.2** 1. Inpatient means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist. 2. Inpatient hospital services means services that: a. Are ordinarily furnished in a hospital for the care and treatment of inpatients; b. Are furnished under the direction of a physician or dentist. 3. Is maintained primarily for the care and treatment of patients with disorders other than mental diseases; (ii) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting.

Type of Program: ☐ Nursing Facility
☐ GAPP
☐ TEFRA/Katie Beckett

PEDIATRIC DMA 6(A)

PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

Section A – Identifying Information

1. Applicant's Name/Address:

Name: ______________________

Address: ______________________

____

DFCS County: ______________________

2. Medicaid Number: ______________________

3. Social Security Number

4. Sex   Age   4A. Birthdate

5. Primary Care Physician: ______________________

6. Applicant's Telephone # ______________________

7. Does guardian think the applicant should be institutionalized? ☐ Yes ☐ No

8. Does child attend school? ☐ Yes ☐ No

9. Date of Medicaid Application ____/____/____

Name of Caregiver #1: ______________________ Name of Caregiver #2: ______________________

I hereby authorize the physician, facility or other health care provider named herein to disclose protected health information and release the medical records of the applicant/beneficiary to the Georgia Department of Community Health and the Department of Human Services, as may be requested by those agencies, for the purpose of Medicaid eligibility determination. This authorization expires twelve (12) months from the date signed or when revoked by me, whichever comes first.

10. Signature: ______________________ 11. Date: ____/____/____
(Parent or other Legal Representative)

Section B – Physician's Report and Recommendation

12. History: *(attach additional sheet if needed)*

13. Diagnosis	1. ICD	2. ICD	3. ICD
1) ____________ 2) ____________ 3) ____________ *(Add attachment for additional diagnoses)*			

14. **Medications**				15. **Diagnostic and Treatment Procedures**	
Name	Dosage	Route	Frequency	Type	Frequency

16. Treatment Plan **(Attach copy of order sheet if more convenient or other pertinent documents)**

Previous Hospitalizations: ____________ Rehabilitative Services: ____________ Other Health Services: ____________

Hospital Diagnosis: 1) ____________ 2) Secondary ____________ 3) Other ____________

17. Anticipated Dates of Hospitalization: ____________

18. Level of Care Recommended: ☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

19. Type of Recommendation: ☐ Initial ☐ Change Level of Care ☐ Continued Placement

20. Patient Transferred from (check one): ☐ Hospital ☐ Another NF ☐ Private Pay ☐ Lives at home

21. Length of Time Care Needed ____ Months 1) ☐ Permanent 2) ☐ Temporary________estimated

22. Is patient free of communicable diseases? ☐ Yes ☐ No

23. This patient's condition ☐ could ☐ could not be managed by provision of ☐ Community Care or ☐ Home Health Services

24. Physician's Name (Print): ______________________

Physician's Address (Print): ______________________

25. I certify that this patient requires the level of care provided by a nursing facility, IC/MR facility, or hospital

______________________ **Physician's Signature**

26. Date signed by Physician ____/____/____

27. Physician's Licensure No. ______________________

28. Physician's Telephone #: ______________________

Section C– Evaluation of Nursing Care Needed (check appropriate box only)

29. Nutrition	30. Bowel	31. Cardiopulmonary Status	32. Mobility	33. Behavioral S tatus
☐ Regular ☐ Diabetic Shots ☐ Formula-Special ☐ Tube feeding ☐ N/G-tube/G-tube ☐ Slow Feeder ☐ FTT or Premature ☐ Hyperal ☐ IV Use ☐ Medications/GT ☐ Meds	☐ Age Dependent Incontinence ☐ Incontinent - Age > 3 years ☐ Colostomy ☐ Continent ☐ Other ____________	☐ Monitoring ☐ CPAP/Bi-PAP ☐ CP Monitor ☐ Pulse Ox ☐ Vital signs > 2/days ☐ 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 ☐ Mental Retardation ☐ Behavioral Problems (please describe, if checked) ☐ Suicidal ☐ Hostile

34. Integument System	35. Urogenital	36. Surgery	37. Therapy/Visits	38. Neurological Status
☐ Burn Care ☐ Sterile Dressings ☐ Decubiti ☐ Bedridden ☐ Eczema-severe ☐ Normal	☐ Dialysis in home ☐ Ostomy ☐ Incontinent – Age > 3 years ☐ Catheterization ☐ Continent	☐ Level 1 (5 or > surgeries) ☐ Level II (< 5 surgeries) ☐ None	Day care Services ☐ High Tech - 4 or more times per week ☐ Low Tech – 3 or less times per week or MD visits > 4 per month ☐ None	☐ Deaf ☐ Blind ☐ Seizures ☐ Neurological Deficits ☐ Paralysis ☐ Normal

39. Other Therapy Visits ☐ Five days per week ☐ Less than 5 days per week

40. Remarks

41. Pre-Admission Certification Number: ______________________________

42.Date Signed ____/___/____

43. Print Name of MD or RN: ____

Signature of MD or RN: ____

DO NOT WRITE BELOW THIS LINE

44. Continued Stay Review Date: __________ Admission Date: ___________ Approved for ________ Days or __________ Months

45. Are nursing services, rehabilitative services or other health related services requested ordinarily provided in an institution?

☐ Yes ☐ No

46A. State Authority MH & MR Screening

Level I/II

Restricted Auth. Code Date

46B. This is not a re-admission for OBRA purposes

47. Hospitalization Precertification ☐ Met ☐ Not Met

Restricted Auth. Code Date

48. Level of Care Recommended by Contractor ☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

49. Approval Period	50. Signature (Contractor)	51. Date	52. Attachments (Contractor)
	____________________	____/___/____	☐ Yes ☐ No

PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

INSTRUCTIONS FOR COMPLETING THE PEDIATRIC CARE FORM DMA-6(A)

This section provides detailed instructions for completion of the ***Form DMA-6 (A)***. Before payment can be made, a ***Form DMA-6 (A)*** must be completed by the ***Primary Care Physician (PCP) and the parent or legal representative*** and signed by the PCP. The Form DMA-6 (A) is considered valid only if it is signed by the ***Primary Care Physician*** and dated.

Section A - Identifying Information

It is the responsibility of the responsible party to see that Section A of the form is completed with the applicant's name and address.

Item 1: **Applicant's Name and Address**
Enter the complete name and address of the applicant including the city and zip code.

The KB Medicaid Specialist will complete the mailing address and county of the originating application.

Item 2: **Medicaid Number**
Enter the Medicaid number exactly as it appears on the Medicaid card or Form 962. A valid Medicaid number will be formatted in one of three ways:

a. If the member or applicant is in the Medicaid System, the ID number will be the 12-digit number, e.g., 111222333444;

b. If the member or applicant was previously determined eligible by the KB Team staff or making application for services, the number will be the 9-digit SUCCESS number plus a "P", e.g., 123456789P; or

c. If the individual is eligible for Medicaid due to the receipt of Supplemental Security Income (SSI), the number will be the 9-digit Social Security number plus an "S", e.g., 123456789S.

The entire number must be placed on the form correctly. In exceptional instances, it may be necessary to contact the KB Medicaid Specialist for the Medicaid number.

Item 3: **Social Security Number**
Enter the applicant's nine-digit Social Security number.

Item 4&4A: Sex, Age and Date of birth
Enter the applicant's sex, age, and date of birth.

Item 5: **Primary Care Physician**
Enter the entire name of the Primary Care Physician (PCP).

Item 6: **Telephone Number**
Enter the telephone number including area code of the applicant's parent or the legal representative.

Item 7: **Does the parent or legal representative think the applicant should be institutionalized?**
Please check the appropriate box.

Item 8: **Does the child attend school?**
Please check the appropriate box if the member attends school.

Item 9: **Date of Medicaid Application**
Enter the date the family made application for Medicaid services.

Fields below Item 9:
Please enter the name of the primary caregiver for the applicant. If a secondary caregiver is available to care for the applicant, please indicate the name of the caregiver.

Read the statement below the name(s) of the caregiver(s) and then;

Item 10: **Signature**
The parent or legal representative for the applicant should sign the DMA-6 (A).

Item 11: **Date**
Please include the date the DMA-6 (A) was signed by the parent or the legal representative.

Section B - Physician's Examination Report and Recommendation

Item 12: **History (attach additional sheet(s) if needed)**
Describe the applicant's medical history (Hospital records may be attached).

Item 13: **Diagnosis (Add attachment(s) for additional diagnoses)**
Describe the primary, secondary, and any third diagnoses relevant to the applicant's condition on the appropriate lines. Leave the blocks labeled ICD blank. The Contractor's staff will complete these boxes.

Item 14: **Medications (Add attachment(s) for additional medication(s)**
The name of all medications the applicant is to receive should be listed. Name of drugs with dosages, routes, and frequencies of administration are to be included.

Item 15: Diagnostic and Treatment Procedures
Any diagnostic or treatment procedures and frequencies should be indicated.

Item 16: Treatment Plan (Attach copy of order sheet if more convenient or other pertinent documentation)
List previous hospitalization dates, as well as rehabilitative/habilitation, and other health care services the applicant has received or currently receiving. The hospital admitting diagnoses (primary, secondary, and other diagnoses) and dates of admission and discharge must be recorded. The treatment plan may also include other pertinent documents to assist with the evaluation of the applicant.

Item 17: Anticipated Dates of Hospitalization
List any dates the applicant may be hospitalized in the near future for services.

Item 18: Level of Care Recommended
Recommendation regarding the level of care considered necessary. Enter a check in the correct box for hospital, nursing facility, or an intermediate care facility for the mentally retarded.

Item 19: Type of Recommendation
Indicate if this is an initial recommendation for services, a change in the member's level of care, or a continued placement review for the member.

Item: 20: Patient Transferred from (Check one)
Indicate if the applicant was transferred from a hospital, private pay, another nursing facility or lives at home.

Item 21: Length of Time Care Needed
Enter the length of time the applicant will require care and services from the Medicaid program. Check the appropriate box on the length of time care is needed either permanent or temporary. If temporary, please provide an estimate of the length of time care will be needed.

Item 22: Is Patient Free of Communicable Diseases?
Enter a check in the appropriate box.

Item 23: Alternatives to Nursing Facility Placement
The admitting or attending physician must indicate whether the applicant's condition could or could not be managed by provision of the Community Care or Home Health Care Services Programs. Enter a check in the box corresponding to "could" and either/both the box (es) corresponding to Community Care and/or Home Health Services if either/or both is appropriate. Enter a check in the box corresponding to "could not" if neither is appropriate.

Item 24: **Physician's Name and Address**
Print the admitting or attending physician's name and address in the spaces provided.

Item 25: **Certification Statement of the Physician and Signature**
The admitting or attending physician must certify that the applicant requires the level of care provided by a nursing facility, hospital, or an intermediate care facility for the mentally retarded. Signature stamps are not acceptable.

Item 26: **Date signed by the physician**
Enter the date the physician signs the form.

Item 27: **Physician's Licensure Number**
Enter the Georgia license number for the attending or admitting physician.

Item 28: **Physician's Telephone Number**
Enter the attending or admitting physician's telephone number including area code.

Section C - Evaluation of Nursing Care Needed (Check Appropriate box only)

Licensed personnel involved in the care of the applicant should complete Section C of this form.

Item 29: **Nutrition**
Check the appropriate box (es) regarding the nutritional needs of the applicant.

Item 30: **Bowel**
Check the appropriate box(es) to indicate the bowel and bladder habits of the applicant.

Item 31: **Cardiopulmonary Status**
Check the appropriate box (es) to indicate the cardiopulmonary status of the applicant.

Item 32: **Mobility**
Check the appropriate box (es) to indicate the mobility of the applicant.

Item 33: **Behavioral Status**
Check all appropriate boxes (es) to indicate the applicant's mental and behavioral status.

Item 34: **Integument System**
Check the appropriate box (es) to indicate the integument system of the applicant.

Item 35: **Urogenital**
Check the appropriate box (es) for the urogenital functioning of the applicant.

Item 36: **Surgery**
Check the appropriate box regarding the number of surgeries the applicant has had to your knowledge or obtain this information from the parent or other legal representative.

Item 37: **Therapy/Visits**
Check the appropriate box to indicate the amount of therapy visits the applicant receives.

Item 38: **Neurological Status**
Check the appropriate box(es) regarding the neurological status of the applicant.

Item 39: **Other Therapy Visits**
If applicable, indicate the number of treatment or therapy sessions per week the applicant receives or needs.

Item 40: **Remarks**
Indicate the patient's vital signs, height, weight, and other pertinent information not otherwise indicated on this form or any additional comments.

Item 41: **Pre-admission Certification Number**
Indicate the pre-admission certification number (if applicable).

Item 42: **Date Signed**
Enter the date this section of the form is completed.

Item 43: **Print Name of MD or RN**
The individual completing Section C should print their name and sign the DMA-6 (A).

Do Not Write Below This Line
Items 44 through 52 are completed by Contractor staff only.

TEFRA/Katie Beckett Medical Necessity/Level of Care Statement

Member Name:_______________________ DOB: _______ SS#_______________
Diagnosis: ____

____

Recommended level of Care:
☐ Nursing facility level of care ☐ Hospital level of care
☐ Level of care required in an Intermediate Care Facility for MR (ICF-MR)

Medical History: (May attach hospital discharge summary or provide narrative):

____

____

____

Current Needs

	None	Description of Skilled Nursing Needs
Cardiovascular:	____	__________________________________
Neurological:	____	__________________________________
Respiratory:	____	__________________________________
Nutrition:	____	__________________________________
Integumentary:	____	__________________________________
Urogenital:	____	__________________________________
Bowel:	____	__________________________________
Endocrine :	____	__________________________________
Immune:	____	__________________________________
Skeletal:	____	__________________________________
Other:	____	__________________________________

Therapy: Speech sessions/wk ____ PT sessions/wk ____ OT sessions/wk ____ *(attach current notes)*

Hospitalizations within last 12 months: (Attach most recent hospital discharge summary)
Date: _________ Reason: _________ Duration: ______________________
Comments: ____

____

Child in school: _____ Hrs per day _____ Days per wk ___ N/A ____ IEP/IFSP __ *(attach if in effect)*
Nurse in attendance during school day: _____ N/A ____*(attach last month's nursing notes)*

Skilled Nursing hours received: Hrs./day ______ N/A ________
I attest that the above information is accurate and this member meets Pediatric Level of Care Criteria and requires the skilled care that is ordinarily provided in a nursing facility, hospital or facililty whose primary purpose is to furnish health and rehabilitative services to persons with mental retardation or related conditions.

Physician's Signature: __________________________ Date: ___________
Primary Caregiver Signature: __________________________ Date: ___________

**** Foster Care Applicants must have the signature of the DFCS representative.**

DMA – 706
Rev. 04/11

TEFRA/KATIE BECKETT MEDICAL NECCESSITY/LEVEL OF CARE STATEMENT INSTRUCTIONS FOR COMPLETION

This document provides detailed instructions for completion of the TEFRA/Katie Beckett Medical Necessity/Level of Care Statement

Member (Applicant) Information

1. Enter the Member's Name, DOB and SS#

Diagnosis

1. Enter the Member's primary, secondary, and any third diagnoses relevant to the member's condition

Level of Care

1. Enter a check in the correct box for the recommended level of care.

Medical History

1. Provide narrative of member's medical history or attach documents i.e., hospital discharge summary, etc.

Current Needs

1. Check member's current needs and provide description of skilled nursing needs.

Therapy

1. Include frequency per week of therapies and attach current notes.

Hospitalizations

1. Attach most recent hospital discharge summary and document date, reason and duration.

School

1. Enter a check for member's appropriate school attendance and IFSP or IEP plan.

Signature

1. The primary care physician or physician of record must sign and date.
2. The caregiver (parent or guardian) must sign and date. Foster Care members must have the signature of the DFCS representative.

TEFRA/Katie Beckett

Cost-Effectiveness Form

(Child's physician must complete Form)

The following information is requested for the purpose of determining your patient's eligibility for Medicaid:

Patient's Name:______________________________ Medicaid #:______________________________

Diagnosis:____

Prognosis:____

Please provide the estimated **monthly** costs of Medicaid services your patient will need or is seeking for Medicaid to cover for in-home care:

- Physician's services $________________
- Durable medical equipment ________________
- Drugs ________________
- Therapy(s) ________________
- Skilled Nursing Services ________________
- Other(s)_________________ ________________

TOTAL $________________

Will home care be as good or better than institutional care?

__________ Yes __________ No

COMMENTS:

____

____

____

____

PHYSICIAN'S SIGNATURE ____

DATE: ____

DMA Form 704
Rev. 10-04

Instructions for Completing the Katie Beckett Cost-Effectiveness Form

This form should be completed by the Katie Beckett child's primary care physician. Instruct the physician to complete the form as follows:

1. Patient's Name – Enter the name of the Katie Beckett child.
2. The MES may provide the Medicaid number, if not known.
3. The physician should enter the diagnosis name, not the ICD code, and the prognosis in the spaces provided. S/he may attach additional information, if needed.
4. The physician should provide the estimated monthly cost of any of the medical services which the Katie Beckett child regularly receives. If the physician will not complete everything applicable, it is permissible to have other medical service amounts entered by the providing agency/pharmacy/therapist. Have that entity initial next to the dollar amount. At the very least, the physician must complete the cost of his/her services.
5. The physician must indicate if home care will be as good as institutional care.
6. It is not necessary to enter any comments. However, it will be helpful to the MES if you will indicate for each medical service the percentage amount that is covered by any private/group insurance plan.
7. The form must have an original signature of the primary care physician. Stamped signatures are not acceptable. The date should be the date of the signature.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH – THIRD PARTY LIABILITY
HEALTH INSURANCE INFORMATION QUESTIONNAIRE

CASE NAME:____________________________________ CASE NO:_______________________________________

ADDRESS: _____________________________________ SSN: _______________________________________

_____________________________________ PHONE NO:_______________________________________

TYPE OF CASE: ☐ INITIAL APPLICATION ☐ SPECIAL NEEDS TRUST (SNT) ☐ CHANGE ☐ CANCELLATION
(Check all that apply) ☐ HIPP REFERRAL EFFECTIVE DATE OF CHANGE OR CANCELLATION:_____/____/_____

The information obtained on this form is collected by the Georgia Department of Community Health, Third Party Liability Section. The collection of this information is authorized by law (42 U.S.C. 1396(a) (25): 42 CFR 433.135-139). It will be used to determine the liability of third parties to pay for care and services and collection of that liability. Medicaid benefits are not denied based on any applicant having health insurance or medical coverage.

Do you have a private, group or government health insurance that pays any of the cost of your medical care? (Do not include Medicare or Medicaid) ☐ YES ☐ NO

Does your spouse, parent or stepparent have any private, group or government health insurance that pays any of the cost of your medical care? ☐ YES ☐ NO

Is policyholder an Absent Parent? ☐ YES ☐ NO

Names of Covered Individuals in Household (Last) (First) (MI)	Medicaid ID#	SSN	Relationship to Policy Holder (check one)					Date Of Birth
			Policy Holder	Spouse	Child	Step-child	Other	

Are any of these persons pregnant? ☐ YES ☐ NO If yes, Name ____________________________ Date of Delivery________

ATTACH A COPY OF INSURANCE CARD/POLICY AND A COPY OF SNT

Do any of the persons listed above have a chronic medical condition? ☐ YES ☐ NO If yes, Name___________________________________ Condition_________________________________

____(______)______________________
(Insurance Company Name) (Telephone Number)

____
(Address) (City) (State) (Zip)

____
(Policyholder Name) (Policyholder SSN) (Policy Number) (Policyholder DOB)

____
(Policy Effective Date) (Policy Termination Date)

____
(Employer Name) (Telephone Number)

____
(Employer Address) (City) (State) (Zip)

Types of Coverage (circle those which apply)

01 – HOSPITAL INPT.	15 – LTC/NH
07 – DRUG/STND	16 – HMO/DRUG
08 – MAJOR MED.	17 – MED. SUPP A
09 – DENTAL	18 – MED. SUPP B
10 – VISION	22 – HMO/STND

OTHER___________________________________

I authorize the release of information necessary to identify health/liability insurance benefits to the Department of Community Health. I also certify that the above information is correct.

Signed______________________________________ Date____________________
Member or Authorized Person

I hereby assign to the Department of Community Health all rights to payments for benefits of medical services rendered to myself or any of my dependents who receive Medicaid.

Signed________________________________Date_____________
Insured or Authorized Person

EFFECTVIE DATE OF MEDICAID ELIGIBILITY____________________________

Case Worker Name:____ Phone No:_________________________County_________________

DMA-285-REV. (01/06)

**INSTRUCTIONS FOR COMPLETING
GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE
THIRD PARTY LIABILITY
HEALTH INSURANCE INFORMATION QUESTIONNAIRE
FORM DMA-285**

1. LEGIBLY PRINT information in every applicable field on the form.
2. If the DMA-285 is for a legal action, Trust or QIT, write "Legal Action", "TRUST" or "QIT" in red ink at the top of the form.
3. If this form is completed to report a change, personal reimbursement, death or cancellation of an insurance policy, write "Change", "Cancellation", "Death", "Reimbursement", etc. in red ink at the top of the form. You may use a copy of the original 285 sent to DMA if it is legible.
   - If you have a letter confirming cancellation of the policy, attach the letter to the 285.
   - If the A/R has never had the insurance or if it was cancelled several years ago, attach to a 285 a copy of the MHN screen showing the insurance and annotate that the A/R has never had or has not had the insurance in years.
   - If you are reporting the death of an A/R who has a QIT, also write the date of death next to "Death" as MM/DD/YY.
   - If the A/R has personally been reimbursed for a service covered by Medicaid or has received a settlement from a pending legal action, mail/fax a copy of the existing 285 and attach a copy of the Explanation of Benefits (EOB) or letter outlining the settlement that accompanies the check. Attach a copy of the check, if available.
4. Do not submit this form if the only health insurance the A/R(s) have is Medicare or Medicaid.
5. Complete the name and address, etc. of the head of household in the AU as entered in SUCCESS.
6. Check whether the case is for an application or redetermination.
7. If you plan to send this form to DMA for an active policy, trust, etc., check "Yes" to having a private, group or government health insurance…..
8. Check yes or no as appropriate if someone else has health insurance on the A/R(s).
9. Check the appropriate type of policy that exists for the A/R(s). Attach a copy of the front and back of the health insurance card, if possible.
10. If the form is for a trust or QIT, cross out "Policy Holder" and write in "Trustee". Enter the name of the policy holder or trustee.
11. Enter the address of the policy holder or trustee as appropriate.
12. Enter the policy holder's SSN.
13. Enter the phone number of the policy holder or trustee.
14. Enter the name address, policy number and effective date in the appropriate fields. If insurance is cancelled, write "Cancelled" above "Effective Date" and the date cancelled in the space available.
15. If the insurance policy is through an employer, enter the information pertaining to the employment in the spaces provided.

16. List the names of the household members who are Medicaid A/Rs covered under the insurance policy. Enter their relationship to the A/R given as the "Case Name" at the top of the form. If it's the same write "Self". Provide the date of birth. Enter the SUCCESS ID #. Enter the SSN of the individual.
17. If possible, have the A/R or PR sign the document in the two spaces provided.
18. The worker should LEGIBLY PRINT his/her name, DIRECT phone number and DFCS county.
19. See Section 2230 for mailing/faxing instructions.

NOTE: PCG, the entity charged with handling DMA-285, has a 30 day standard of promptness. If it is necessary to have an immediate correction made concerning a TPR, fax the information to PCG rather than mailing. At times MHN may show insurance coverage that the MES is not aware of. Always double check with the A/R before assuming that the insurance shown is not valid. However, a pharmacy should never deny a member their prescriptions because of TPR issues. They have override codes to enter to make the prescription claim be accepted.

We will consider this application without regard to race, color, sex, age, disability, religion, national origin or political belief.

MEDICAID APPLICATION

FOR COUNTY USE ONLY:
Date Received in County Dept

Check block(s) that apply to you:

❑ Pregnant Woman ❑ Families w/Children – LIM
❑ Child(ren) Only – RSM ❑ Chafee Independence Program Medicaid
Were you in foster care on your 18th birthday? ☐ Yes ☐ No In which state?______

PLEASE NOTE: A Face to Face interview is not required for Medicaid applications. Please answer all questions as completely and accurately as possible. If you cannot understand or complete this application, please notify DFCS staff and assistance will be provided free of charge.

Your Name: (Please Print) FIRST M.I. Last Maiden (if applicable)			Today's Date:	
Mailing Address:	City:		State:	Zip Code:
Residence Address (if different from Mailing Address):	Phone Number(s):		E-mail Address:	

Please list all persons living with you for whom you want Medicaid. List yourself if you want Medicaid for yourself.

First Name	MI	Last Name	Suffix (Jr.)	Race	Sex M/F	Date of Birth	Relationship to You	Social Security Number	Is this Person a U.S. Citizen? (Y/N) (you may qualify for Medicaid even if you answer No)		Does the Father of this child live in your home? (Y/N)		Does the Mother of this child live in your home? (Y/N)	

Please list all persons living with you for whom you DON'T want Medicaid. List yourself if you don't want Medicaid. You do not have to provide a SSN or immigration status information for any person who is not asking for Medicaid. If provided, we will use the SSN for computer matches with other agencies and it may help us process your child's application. We will NOT share your information with the Department of Homeland Security (formerly the INS).

Is anyone in the household pregnant? ❑ Yes ❑ No If yes, who is pregnant? _________________________ Due Date: ____________ Please attach verification of pregnancy if available.

Do you have any unpaid medical bills from the past three months? ❑ Yes ❑ No If yes, which months? ________________________________

Does anyone in your household have Health Insurance? ❑ Yes ❑ No If yes, list Insurance Company and policy number:

Have you or anyone in your household been diagnosed with Breast or Cervical Cancer? ❑ Yes ❑ No If yes, have you received Women's Health Medicaid previously? ❑ Yes ❑ No

INCOME, RESOURCES and DAYCARE

List all income received by persons on page 1 of this application. Be sure to show the amount before deductions. Attach an extra sheet if necessary. We will decide, based on the type of Medicaid, whose income must be counted and whose may be excluded. **If you are applying for Children Only or Pregnant Woman Medicaid, you do not have to complete the Resources/Vehicles sections below.**

Income	Gross Amount per Pay Check (amount before deductions)	How Often? (weekly, every 2-weeks, monthly, etc.?)	Name of Person Receiving
Wages/Earnings			
Current Employer:			
Wages/Earnings			
Current Employer:			
Social Security Income/SSI			
Worker's Compensation			
Pensions or Retirement Benefits			
Child Support/ Contributions			
Unemployment Benefits			
Other Income, please specify:			

Resources	Amount in Account/Value	Who Owns Resource?
Cash		
Checking Account		
Savings Account		
Credit Union		
401K/Retirement Account		
Other		

Vehicle(s): Cars, trucks, motorcycles (licensed)

Make	Model	Year	Amount Owed?

Do you pay for dependent care (daycare for a child or care for an adult who cannot care for himself/herself) so that someone in your household can work?

Name of Parent who works	Name of child or adult cared for	Name of care provider	Amount of Payment	How Often? (weekly, 2-weeks, monthly, etc)

If you are applying for Medicaid for children and one or both of their parents are not in the home, please provide the following information:

Child's Name	Absent Parent's Name (Mother/Father)	Do they have Medical Coverage on the Child? Yes/No	If Yes to Medical Coverage, please list name of insurance company & group number

I understand that this information may need to be verified to determine eligibility. I understand wage and salary information supplied by the Georgia Department of Labor may be obtained to verify and determine eligibility for Medicaid. I agree to assign to the state all rights to medical support and third party support payments (hospital and medical benefits). I agree to give the State the right to require an absent parent provide medical insurance, if available. I understand I must get medical support from the absent parent if it is available and must cooperate with the Division of Child Support Services in obtaining this support. If I do **not** cooperate, I understand I may lose my Medicaid benefits, and only my children will receive benefits unless good cause is established. I understand that I must report changes in my income and circumstances within ten (10) days of becoming aware of the change.

❑ I certify under penalty of perjury that I am a U.S. Citizen and/or lawfully present in the United States. If I am a parent or legal guardian, I certify that the applicant(s) is a U.S. Citizen and/or lawfully present in the United States. ❑ I certify to the best of my knowledge and belief that the person(s) for whom I am applying for Medicaid is/are U.S. citizen(s) or are lawfully present in the United States. I further certify that all of the information provided on this application is true and correct to the best of my knowledge.

Signature (Required): ______________________________ Date: ____________________

DECLARATION OF CITIZENSHIP/ALIEN STATUS

Georgia Department of Human Resources
Division of Family and Children Services

I understand that the Georgia Division of Family and Children Services (DFCS) may require verification from the United States Department of Homeland Security (DHS) of my/my children's citizenship or alien status when seeking benefits. Information received from DHS may affect my/my children's eligibility.

Please fill out and sign **ONE or BOTH** of the following statements as it pertains to the status of each person seeking benefits.

CHILDREN SEEKING BENEFITS

Name	Place of Birth(city,state,country)	U.S. Citizen (check whichever applies)	Lawfully Admitted Immigrant (check whichever applies)	Date Naturalized or Admitted into U.S. (If applicable)

I, ____________________________ attest to the identity of the child/children listed above and
(PRINT NAME)
certify under penalty of perjury, that the information written and checked above is true.

______________________________________ ______________________________
SIGNATURE (PARENT/GUARDIAN) (DATE)

ADULT(S) SEEKING BENEFITS

Name	Place of Birth(city,state,country)	U.S. Citizen (check whichever applies)	Lawfully Admitted Immigrant (check whichever applies)	Date Naturalized or Admitted into U.S. (If applicable)

I, ____________________________ certify under penalty of perjury, that the information
(PRINT NAME)
written and checked above is true.

______________________________________ ______________________________
SIGNATURE (PARENT/GUARDIAN) (DATE)

______________________________________ ______________________________
SIGNATURE (PARENT/GUARDIAN) (DATE)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH – THIRD PARTY LIABILITY
HEALTH INSURANCE INFORMATION QUESTIONNAIRE

CASE NAME:_____________________________________ CASE NO:_______________________________________

ADDRESS: ______________________________________ SSN: ____

______________________________________ PHONE NO:_______________________________________

TYPE OF CASE: ☐ INITIAL APPLICATION ☐ SPECIAL NEEDS TRUST (SNT) ☐ CHANGE ☐ CANCELLATION
(Check all that apply) ☐ HIPP REFERRAL EFFECTIVE DATE OF CHANGE OR CANCELLATION:_____/____/_____

The information obtained on this form is collected by the Georgia Department of Community Health, Third Party Liability Section. The collection of this information is authorized by law (42 U.S.C. 1396(a) (25): 42 CFR 433.135-139). It will be used to determine the liability of third parties to pay for care and services and collection of that liability. Medicaid benefits are not denied based on any applicant having health insurance or medical coverage.

Do you have a private, group or government health insurance that pays any of the cost of your medical care? (Do not include Medicare or Medicaid) ☐ YES ☐ NO

Does your spouse, parent or stepparent have any private, group or government health insurance that pays any of the cost of your medical care? ☐ YES ☐ NO

Is policyholder an Absent Parent? ☐ YES ☐ NO

Names of Covered Individuals in Household (Last) (First) (MI)	Medicaid ID#	SSN	Relationship to Policy Holder (check one)					Date Of Birth
			Policy Holder	Spouse	Child	Step-child	Other	

Are any of these persons pregnant? ☐ YES ☐ NO If yes, Name ____________________________ Date of Delivery________

ATTACH A COPY OF INSURANCE CARD/POLICY AND A COPY OF SNT

Do any of the persons listed above have a chronic medical condition? ☐ YES ☐ NO If yes, Name___________________________________ Condition_________________________________

____(______)______________________
(Insurance Company Name) (Telephone Number)

____
(Address) (City) (State) (Zip)

____
(Policyholder Name) (Policyholder SSN) (Policy Number) (Policyholder DOB)

____
(Policy Effective Date) (Policy Termination Date)

____
(Employer Name) (Telephone Number)

____
(Employer Address) (City) (State) (Zip)

Types of Coverage (circle those which apply)

01 – HOSPITAL INPT. 15 – LTC/NH
07 – DRUG/STND 16 – HMO/DRUG
08 – MAJOR MED. 17 – MED. SUPP A
09 – DENTAL 18 – MED. SUPP B
10 – VISION 22 – HMO/STND
OTHER___________________________________

I authorize the release of information necessary to identify health/liability insurance benefits to the Department of Community Health. I also certify that the above information is correct.

Signed_______________________________________ Date____________________
Member or Authorized Person

I hereby assign to the Department of Community Health all rights to payments for benefits of medical services rendered to myself or any of my dependents who receive Medicaid.

Signed________________________________Date_____________
Insured or Authorized Person

EFFECTVIE DATE OF MEDICAID ELIGIBILITY_____________________________

Case Worker Name:____ Phone No:_________________________County_________________

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agency. If you have questions, please contact your local county Medicaid case manager.

CITIZENSHIP/IDENTITY VERIFICATION CHECKLIST

AU NAME: ____________________

AU NUMBER: ____________________

CITIZENSHIP/IDENTITY MUST BE VERIFIED FOR ALL MEDICAID APPLICATIONS/REVIEWS

If you have already provided acceptable verification of your citizenship/identity as listed below, or are a recipient of SSI or Medicare further verification is not necessary. Please check with your Medicaid case manager for clarification. Please provide one of the following, and return to your county DFCS case manager.

No Identity Required on these Citizenship Verifications:

- US Passport (not limited passports)
- Certificate of Naturalization (N-550 or N-570)
- Certificate of Citizenship (N-560 or N-561)

Identity Required with these Citizenship Verifications:

- US Public Birth Record showing birth in one of the 50 states; District of Columbia; American Territories; or Guam
- US birth certificate or data match with a State Vital Statistic Agency
- Certification of Report of Birth (DS-1350)
- Consular Report of Birth Abroad of a Citizen of the U.S.(FS-240)
- Certification of Birth Abroad (FS-545)
- United States Citizen Identification Card (I-197 or the prior version I-179)
- American Indian Card (I-872) with the classification KIC(Issued by DHS to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.
- Collective Naturalization document/Northern Mariana Identification Card (I-873)
- Final Adoption Decree
- Evidence of civil service employment by the US government
- Official Military record
- Federal or State census record showing US citizenship indicating a US place of birth
- Tribal census record for Seneca Indian tribe or from Bureau of Indian Affairs
- Statement signed by the physician or midwife who was in attendance at the time of birth
- One of the following documents created at least 5 years before the application for Medicaid showing a US place of birth :
  - Extract of hospital record on hospital letterhead established at the time of person's birth
  - Life, health or other insurance record
  - An amended US public birth record
  - Medical clinic(not Health Dept.), doctor or hospital record indicating a US place of birth
  - Institutional admission papers from nursing home, skilled nursing care facility or other institution

If you do not have any of the above, please contact your case manager to complete an affidavit of citizenship or identity.

Acceptable Verification of Identity:

- State Driver's license bearing the individual's picture **or** Georgia Identification Card
- Certificate of Indian Blood; US American/Alaska Native tribal document; or Native American Tribal Document
- US Military Card or draft record; Military dependent's ID card with photograph; US Coast Guard Merchant Mariner Card
- Identification card issued by federal, state or local government agencies or entities with photo or identifying information
- School Identification card with a photograph
- US passport issued with Limitations
- Data matches or documents from law enforcement or corrections agencies such as police or sheriff's departments, parole office, DJJ and Youth Detention Centers

For individuals under age 16 who are unable to produce a document listed above, the following documents are acceptable to establish identity only:

- School record including report card, daycare or nursery school record. (Must verify record with issuing school)
- Clinic, doctor or hospital record showing date of birth. An immunization record is acceptable if it is part of a medical record certified by the medical provider.
- Affidavit signed under penalty of perjury by a parent/guardian. **(Contact your case manager at the county DFCS.)**
- A signed Declaration of Citizenship form that includes the date and place of birth of the child. **(Contact your case manager at the county DFCS.)**

All documents that verify citizenship must be either ORIGINALS or copies CERTIFIED by issuing

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