TEFRA/Katie Beckett
Level-of-Care Determination Routing Form/Checklist

DATE SENT: _____________

TO: **Georgia Medical Care Foundation (GMCF)**
ATTN: TEFRA/Katie Beckett
P.O. Box 105406
Atlanta, GA 30348

FROM: **RSM Katie Beckett Medicaid Team**

Medicaid Specialist's Name: __________________________ Direct Phone #: ______________

Medicaid Specialist's E-mail Address: ____

Medicaid Specialist's Mailing Address: ____

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RE: Applicant's Name:

Applicant's Address:

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Applicant's SSN: ____

Parent(s)/Guardian Name: ____

Physician Name: ____

A **complete packet** must be submitted to GMCF for the **Level of Care Determination review**. A complete packet consists of the following:

____ DMA-6A*
____ TEFRA/Katie Beckett Medical Necessity/Level of Care Statement *
____ Psychological, IQ test or Adaptive Functioning Evaluation (only required for children with mental retardation or related conditions such as Cerebral Palsy, Epilepsy, Autism, Autism-Spectrum Disorder, Asperger's Syndrome, Down's Syndrome, Pervasive Developmental Disorder or other Developmental Delays (required with initial application for ICF/MR determinations and every three years)
____ IEP or IFSP (if one is in effect) *
____ Rehab Therapy/Nursing Notes (if applicable)

* Required for all level of care determinations

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