TEFRA/Katie Beckett Medical Necessity/Level of Care Statement

Member Name: _____DOB: _____ SS#_____
Diagnosis: _____
_____

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

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 ___
Nurse in attendance during school day: _____ N/A _____(Attach most recent 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 or facililty whose primary purpose is to furnish health and rehabilitative services to persons with intellectual disabilities or related conditions.

Physician's Signature: _____ Date: _____
Primary Caregiver Signature: _____ Date: _____

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

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. It may be completed by physician and the primary caregiver.

Member (Applicant) Information

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

Diagnosis

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

Level of Care

Check the correct box for the recommended level of care.

Medical History

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

Current Needs

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

Therapy

Therapies require a plan of care. All therapies, including school based therapies, must be ordered by a physician and accompanied by current individually signed therapy notes.

Hospitalizations

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

School

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

Signature

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