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

PEDIATRIC DMA 6(A)
PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

Section A – Identifying Information

1. Applicant's Name/Address: Susie Smith

DFCS County Fulton

123 Jump Street, Atlanta, GA 30338
Mailing Address

2. Medicaid Number: Initial application

3. Social Security Number: XXX-XX-XXXX

4. Sex: F

Age: 18mos

4A. Birthdate: XX-XX-20XX

5. Primary Care Physician: John Johnson, Johnson Pediatrics, 1001 N Atlanta Rd, Atlanta

6. Applicant's Telephone # 404.770.6780

7. In the caretaker's opinion, would the child require institutionalization if the child did not receive community services? ☑ Yes ☐ No

8. Does child attend school? ☐ Yes ☑ No

9. Date of Medicaid Application / /

Name of Caregiver #1: Eric Smith Name of Caregiver #2: Ariel Smith

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 Department of Community Health and the Department of Human Resources, 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)*

See attachment

13. Diagnosis

1) Chromosomal abnormality 2) Gloal developmental delay 3) See attachment
(Add attachment for additional diagnoses)

1. ICD	2. ICD	3. ICD
X11.1	Z22.2	

14. **Medications**

Name	Dosage	Route	Frequency
None			

15. **Diagnostic and Treatment Procedures**

Type	Frequency
Blood transfusion	Monthly
Neurology exam	Annually
Cardiology exam	Annually

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

Previous Hospitalizations: None Rehabilitative/Habilitative Services: See attachment Other Health Services: _____

Hospital Diagnosis: 1) N/A 2) Secondary _____ 3) Other _____

17. Anticipated Dates of Hospitalization: N/A / _____ / _____

18. Level of Care Recommended: ☐ Nursing Facility ☑ ICF/ID 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 be managed by provision of ☑ Community Care or ☑ Home Health Services

24. Physician's Name (Print): John Johnson

Physician's Address (Print): 1001 N Atlanta Rd, Atlanta

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

_____ Physician's Signature

26. Date signed by Physician

27. Physician's Licensure No. 12345

28. Physician's Telephone #: 404)770 6780

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

29. Nutrition	30. Bowel	31. Cardiopulmonary Status	32. Mobility	33. Behavioral Status
☐ 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 ☐ 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 ☑ 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 ☐ Catheterization ☐ Continent ✓ Age dependent incontenence	☐ 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

See attached Psychological Evaluation for assesment scores

41. Pre-Admission Certification Number

42. Date Signed

43. Print Name of MD or RN: John Johnson

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/habilitative services or other health related services requested ordinarily provided in an institution? ☐ Yes ☐ No ☐ NA

46A. State Authority MH & MR Screening)

Level I/II

Restricted Auth. Code Date

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

Restricted Auth. Code Date

47. Hospitalization Precertification ☐ Met ☐ Not Met

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	