# TEFRA/Katie Beckett Medical Necessity/Level of Care Statement

Member Name: Susie Smith DOB: xx-xx-xxxx SS# xxx-xx-xxxx
Diagnosis: Chromosomal abnormality, autism, global developmental delay, hypotonia, macrocephaly

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):
Patient presented with low muscle tone resulting in feeding issues at birth, followed by significant developmental delays. Genetic testing was completed at 12 months with a result of _____ syndrome, which results in autism, hypotonia, and macrocephaly.

## Current Needs

| | None | Description of Skilled Nursing Needs |
|---|---|---|
| Cardiovascular: | ✓ | |
| Neurological: | | Physical, occupational, speech, and music therapy |
| Respiratory: | ✓ | |
| Nutrition: | | Feeding therapy |
| Integumentary: | | |
| Urogenital: | | Incontinent - age dependent |
| Bowel: | | Incontinent - age dependent |
| Endocrine : | ✓ | |
| Immune: | | Immuno compromised |
| Skeletal: | ✓ | |
| Other: | | |

✓

Therapy: Speech sessions/wk 3 PT sessions/wk 3 OT sessions/wk 2
(Attach current notes)

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

Child in school: No 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.**