**5. Private/Other Insurance**

**SOURCE(S) OF INFORMATION**

- Other review
- PACE Program

**6. MEDICAID ELIGIBLE?**

- Yes
- No if no date applied for Medicaid

**7. PRESENT ADDRESS (Specify Facility Name When Applicable)**

- Home
- Hospital
- Care Home
- EARCH
- CCFFH
- Other:

**8. Medicaid Provider Number:**

- (If applicable)

**9. ATTENDING PHYSICIAN/PRIMARY CARE PROVIDER (PCP) (Last Name, First Name, Middle Initial)**

- Phone: (   )
- Fax: (   )

**10. RETURN FORM TO (SERVICE COORDINATOR OR CONTACT PERSON):**

- Managed Care Plan Name (IF APPLICABLE): ____________________________
- [ ] VIA FAX (Print Fax Number Below)
- Phone: (   )
- Fax: (   )
- Email: (   )

**11. REFERRAL INFORMATION (Completed by Referring Party)**

<table>
<thead>
<tr>
<th>A. SOURCE(S) OF INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Client □ Records □ Other</td>
</tr>
</tbody>
</table>

**B. PARENT/LEGAL GUARDIAN/RESPONSIBLE PARTY:**

- Name ____________________________
- Last: __________ First: __________ MI: __________
- Relationship ____________________________
- Phone: (   )
- Fax: (   )

**C. Language □ English □ Other**

**12. ASSESSMENT INFORMATION**

**A. ASSESSMENT DATE_______/_______/_______**

**B. ASSESSOR’S NAME**

- Name __________________________________
- Last: __________ First: __________ MI: __________
- Title: ____________________________
- Signature ____________________________
- Phone: (   )
- Fax: (   )
- Email: (   )

**13. REQUESTING LEVEL OF CARE**

**CHECK ONE BOX:**

- [ ] Nursing Facility (ICF)
- [ ] Nursing Facility (SNF)
- [ ] Nursing Facility (HOSPICE)
- [ ] Nursing Facility (Subacute I)
- [ ] Nursing Facility (Subacute II)
- [ ] Acute Waitlist (ICF)
- [ ] Acute Waitlist (SNF)
- [ ] Acute Waitlist (Subacute)

**LEVEL OF CARE BEGIN and END DATES: __________ TO __________**

**14. MEDICAL NECESSITY / LEVEL OF CARE DETERMINATION – DO NOT COMPLETE**

**LEVEL OF CARE APPROVAL:**

- [ ] Nursing Facility (ICF)
- [ ] Nursing Facility (SNF)
- [ ] Nursing Facility (HOSPICE)
- [ ] Nursing Facility (Subacute I)
- [ ] Nursing Facility (Subacute II)
- [ ] Acute Waitlist (ICF)
- [ ] Acute Waitlist (SNF)
- [ ] Acute Waitlist (Subacute)

**LEVEL OF CARE BEGIN and END DATES: __________ TO __________**

**LENGTH OF APPROVAL (CHECK ONE BOX):**

- [ ] 1 month
- [ ] 3 months
- [ ] 6 months
- [ ] Other: ____________________________
1. **NAME** (PRINT Last Name, First Name, Middle Initial)  

2. **BIRTHDATE**

3. **FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS**

   A. **LIST CURRENT SIGNIFICANT DIAGNOSIS(ES):**

   - **PRIMARY:**
     - Ventilator
     - Tracheostomy
     - Oxygen therapy

   - **SECONDARY:**
     - Nebulized Medications
     - Vascular access catheter
     - Parenteral nutrition

4. **Nursing Intervention**  

   - **Frequency/Complexity**
     - Continuous
     - Intermittent, specify time on ventilator
     - TID or less
     - >TID

5. **MEDICATION/TREATMENTS** (Attach additional sheet if necessary)

   - **List all Significant Medications, Dosage and Frequency**
     - Gastrostomy/jejunostomy/nasogastric tube
     - Pump feedings
     - Urinary bladder catheterization
     - Splint/cast (each)
     - Isolation/reverse isolation
     - Enteral Medications
     - IM/SQ medications

   - **IM/SQ medications**
     - 4 doses/day or less
     - >4 doses/day

   - **IV medications**
     - 4 doses/day or less
     - >4 doses/day

   - **Oral medications**
     - Less than 12 doses/day
     - 12 or more doses/day

   - **Monitor (Apnea, Pulse Oximeter, C-R)**
     - Localized
     - Extensive (describe)

   - **Special Skin Care (Burn, decubiti)**
     - Localized
     - Extensive (describe)

   - **Wound Care (describe):**
     - Restorative therapy (PT, OT, Speech – include treatment plan)
     - Comatose

   - **Initial discharge from hospital**
     - Readmission for exacerbation of existing medical condition or new diagnosis
     - Acute, episodic illness requiring physician or emergency room visits
     - Other specialized nurse interventions (explain):

   - **Address:** ____________________________  
     - **Phone:** ____________________________  
     - **Fax:** ____________________________  
     - **Email address:** ________________________________

6. **ACTIVITIES OF DAILY LIVING**  

   - Identify only assistance required due to developmental delays:
     - Feeding  
     - Transferring  
     - Mobility/Ambulation  
     - Toileting  
     - Bathing  
     - Dressing/Grooming  
     - Enteral Medications
     - Oral medications
     - IM/SQ medications

7. **FAMILY/SOCIAL CONSIDERATIONS**

   - 1. Child can return home  
     - Yes  
     - No  
     - NA

   - 2. Community setting can be considered as an alternative to facility?  
     - Yes  
     - No  
     - NA

   - 3. If child has a home, caregiving support system is willing to provide/continue care?  
     - Yes  
     - No  
     - NA

   - **a. Assistance required by Caregiver:** ____________________________

   - **b. Caregiver Name/relationship:** ____________________________  
     - **Address:** ____________________________  
     - **Phone:** ____________________________  
     - **Fax:** ____________________________  
     - **Email address:** ________________________________

8. **ADDITIONAL INFORMATION**

   - Additional information concerning functional status and justification for LOC, i.e. apnea events, transitioning from tube feeds, isolette, parent teaching/training, behavior, communication, vision etc:
     - ____________________________________________________________
     - ____________________________________________________________
     - ____________________________________________________________
     - ____________________________________________________________
     - ____________________________________________________________
     - ____________________________________________________________

9. **I HAVE REVIEWED AND AGREE WITH THE LEVEL OF CARE ASSESSMENT.**

   - RN, PCP (MD, DO, APRN-Rx, PA) Signature: ____________________________  
   - RN, PCP (MD, DO, APRN-Rx, PA) Name (Print): ____________________________

   - Hard copy signature on file. This plan of care has been discussed with the RN or PCP

   - Date: ____________________________