

PART II
POLICIES AND PROCEDURES
for
TEFRA/KATIE BECKETT DEEMING WAIVER



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

Version Date: July 1, 2025

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Policy Revision Record
[from 2025 to Current¹]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added D=Deleted M=Modified	(Revision required by Regulation, Legislation, etc.)
06/13//2025	205	Changed LOC cost-effectiveness monthly amount	M	
05/29/2025	Appendix B	Added Parent/Guardian to signature line	A	
05/29/2025	Appendix I	Added hospital to line #25 and instructions Item #25	A	
04/21/2025	103.3.3	Added Psychiatrists, and Primary Care Physicians	A	
04/21/2025	203.3	Deleted GMCF and added Alliant	M	
04/21/2025	102.1.1	Changed to age 18 and under	M	
04/01/2025	Appendix R	Added comprehensive appendix which includes links to the websites providing information on Georgia Families 360 and NEMT.	M	
04/01/2025	Appendix C	Added No and Yes section to the form, and added form number 706	A	
04/01/2025	Appendix I	Changed revision date from 08/2024 to 10/2024	M	
04/01/2025	Appendix I-1	6A instructions Item 18 added hospital	A	

¹

The revisions outlined in this Table are from April 1, 2025, to current. For revisions prior to April 1, 2025, please see prior versions of the policy.

TEFRA/Katie Beckett Deeming Waiver
Chapter 100: Introduction

101. Background

The Department of Community Health (DCH) provides Medicaid benefits under the TEFRA/Katie Beckett Medicaid program as described under §134 of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248). States are allowed, at their option, to make Medicaid benefits available to children (age 18 or under) at home who qualify as disabled individuals under §1614(a) of the Social Security Act, provided certain conditions are met, even though these children would not ordinarily be eligible for Supplemental Security Income (SSI) benefits because of the deeming of parental income or resources. The specific statutory provisions establishing this option are contained in §1902(e) of the Social Security Act.

To establish Medicaid eligibility for a child under this program, it must be determined that:

- 101.1. If the child was in a medical institution, he/she would be eligible for medical assistance under the State plan for Title XIX.
- 101.2. The child requires a level of care provided in a hospital, skilled nursing facility, or intermediate care facility (including an intermediate care facility for the intellectually disabled);
- 101.3. It is appropriate to provide the care to the child at home; and
- 101.4. The estimated cost of caring for the child outside of the institution will not exceed the estimated cost of treating the child within the institution.

The Department reviewed the procedure for determining which children qualify medically for the TEFRA/Katie Beckett coverage in 2003. A sub-committee comprised of legal, clinical and eligibility staff met over several months to revise the criteria used in making the medical necessity and level of care determinations.

In the past, the same medical criteria were used for adults and children. The criteria used to determine a child's eligibility in the program is found in Title 42 Code of Federal Regulations. Medical necessity is not based on specific medical diagnoses. The reviewer must review all available medical information to determine whether services are medically necessary. In addition, the reviewer must determine whether the child requires the level of care provided in a hospital, nursing facility, or intermediate care facility (including an intermediate care facility for the intellectually disabled). DCH has developed standardized forms to be used in obtaining the information needed for the disability, level of care and cost effectiveness determinations. Alliant Health Solutions (AHS) the vendor is responsible for making the level of care determinations, and the Centralized Katie Beckett Team are trained on the criteria.

The Level of Care criteria review guidelines have been revised to reflect more examples of pediatric-specific cases. The Level of Care criteria is used for all Initial applications submitted to AHS. The Level of Care criteria is also used for the periodic review of medical eligibility. Once the child's records have been reviewed, a Level of Care determination is made by the Katie Beckett Review

Team at AHS. Parents /caregivers will be notified via a Letter of Determination. Information regarding the Right to an Appeal will accompany all Letters of Determination. Parents not satisfied with the determination regarding the level of care have the right to request an Administrative Review or an Administrative Hearing. Refer to Section III regarding the Hearing and Appeals Process.

102. What is TEFRA/“Katie Beckett”?

TEFRA is section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) allowing states to make Medicaid services available to certain disabled children who would not ordinarily be eligible for Supplemental Security Income (SSI) benefits because of their parents’ income. Income qualifications for TEFRA/” Katie Beckett” are based solely on the child’s income, but a number of different factors are considered for approval. If approved, the same eligibility for health coverage will be available to the child as to other Medicaid members.

102.1. Eligibility for Medicaid under TEFRA/ “Katie Beckett” will only be approved if ALL the following conditions are met:

102.1.1. Child is 18 years or under. (Rev. 04/2025)

102.1.2. Child meets the federal criteria for childhood disability.

102.1.3. Child meets an institutional level of care criteria.

102.1.4. Even though the child may qualify for institutional care, it is appropriate to care for the child at home.

102.1.5. The Medicaid cost of caring for the child at home does not exceed the Medicaid cost of appropriate institutional care.

The childhood disability determination is completed by the Alliant Health Solutions Medical Review Team.

The child must require an institutional level of care provided in a hospital, nursing facility or intermediate care facility for the intellectually disabled as defined in 42 C.F.R. 435.225(b) (1).

The child’s physician is required to certify that it is appropriate to provide care for the child in the home setting. The Medicaid cost of caring for the child at home must be less than the cost of caring for the child in an institution. The Katie Beckett (KB) Team will be responsible for the cost-effective determination task.

103. Policy and Procedural Changes

103.1. No procedural changes were made in the categorical eligibility determination section in 2003.

103.2. Level of Care Determinations

Alliant Health Solutions (AHS) determines whether the child requires a level of care (LOC) provided in a hospital, skilled nursing facility, or intermediate care facility (including an intermediate care facility for the intellectually disabled) for the TEFRA/Katie Beckett Medical program. The Department developed a new DMA-6 form specifically for children – Pediatric DMA-6(A), Physician’s Recommendation Concerning Nursing Facility Care or Hospital Care (PediatricDMA-6(A)). The form may be reproduced locally. The Department is also working on making the form interactive within the GAMMIS web portal, www.mmis.georgia.gov/portal.

To make the LOC determination, the KB Medicaid Specialist must submit a complete packet of documents to AHS, consisting of the Pediatric DMA- 6(A), Medical Necessity/Level of Care Statement, Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP), and Psychological Evaluation, if necessary. These documents must be completed and submitted to AHS as part of the LOC determination. In most cases, the family will be responsible for submitting this information to the KB Team. However, there may be instances when the KB Medicaid Specialist must assist the family in obtaining the necessary information.

All medical level of care determinations that are verified to meet the standard for Katie Beckett approval will be authorized for a period of no less than two (2) years. This authorization applies ONLY to the medical level of care review.

103.3. Application Requirements for LOC Review

103.3.1. Pediatric DMA-6(A) Form

The Pediatric DMA-6(A) form has been developed to appropriately capture pertinent information regarding the medical needs and care of the child. The DMA-6(A) form must be completed in its entirety, signed and dated by the physician and parent prior to being submitted to AHS. The 30-day period of validity has been changed to 90 days. Instructions for completion of the DMA-6(A) form are included in the appendices of this manual. The DMA-6(A) form must be completed at the time of application, and at each periodic redetermination of eligibility. Clinical information obtained from the DMA-6(A) is used to determine level of care.

103.3.2. Medical Necessity/Level of Care Statement

The Medical Necessity/Level of Care Statement form must be completed, signed, and dated by the physician and the primary caregiver at a minimum. Other members of the planning team may participate in the completion of this form. The planning team may include, but is not limited to, the child’s primary and secondary caregivers, physician, nursing provider, social worker, and therapist(s) (i.e., physical, occupational, speech). A copy of the Medical Necessity/Level of Care Statement is included in the appendices of this manual. A current Medical Necessity/Level of Care Statement plan must be completed at the time of application and at each periodic redetermination of eligibility.

103.3.3. Psychological Assessment

An evaluation is performed by a licensed certified professional to assess the child's level of intellectual capacity. If the child has a diagnosis or condition that results with cognitive impairment Alliant Health Solutions (AHS) will request that the caregiver obtain and submit a psychological or developmental assessment. The following diagnoses require a psychological or developmental assessment:

- 103.3.3.1. Cerebral Palsy
- 103.3.3.2. Developmental Delay
- 103.3.3.3. Autism
- 103.3.3.4. Autism-Spectrum Disorder
- 103.3.3.5. Asperger Syndrome
- 103.3.3.6. Pervasive Developmental Disorder
- 103.3.3.7. Intellectual Disability
- 103.3.3.8. Epilepsy
- 103.3.3.9. Down's Syndrome, and
- 103.3.3.10. Any diagnoses related to the above listed diagnoses.

A comprehensive psychological evaluation must be performed and the level of intellectual disability with appropriate treatment intervention must be stated. The psychological evaluation must be completed by a licensed professional and is required every three (3) years. Licensed professionals approved to do this testing include Developmental Pediatricians, Psychiatrists, Primary Care Physicians and Ph.D. Psychologists. (Rev. 04/2025) Psychological evaluations completed by school psychologists, preschool diagnosticians, and education diagnosticians with M.Ed., Ed.S., M.A., M.S., CAS, CAGS, Psy.S, Psy.D, SSP, or Ed.D degrees are also accepted. Developmental Evaluations done by Early Interventionist with Babies Can't Wait are accepted for children with an Individualized Family Service Plan (IFSP). Also, an IFSP or an Individualized Education Plan (IEP) must be submitted, if in place. All of the above documents and the psychological assessment may be used to determine disability and level of care.

- 103.3.4. Parents should submit the complete packet of documents to the Centralized Katie Beckett unit at the address below:

Centralized Katie Beckett Unit
2211 Beaver Ruin Rd. Suite 150
Norcross, GA. 30071
678-248-7449 Office 678-248-7459 Fax

Chapter 200: Institutional Level of Care (LOC) Criteria

All references to ICF/MR and mental retardation have been updated to ICF/ID and intellectual disability.

As provided in 42 C.F.R 435.225(b) (1), the child must require the level of care provided in a hospital, nursing facility, or intermediate care facility for the intellectually disabled (ICF/ID).

201. Nursing Facility

- 201.1. Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or other health-related services ordinarily provided in an institution. For an individual who has been diagnosed with a mental illness or intellectual disability, nursing facility level of care services are usually inappropriate unless that individual's mental health needs are secondary to needs associated with a more acute physical disorder.
- 201.2. The criteria set forth herein encompass both "skilled" and "intermediate" levels of care services.
- 201.3. A nursing facility level of care is indicated if all four conditions under the Nursing Facility level of Care criteria, in Appendix F, are met. Conditions are derived from 42 C.F.R. 409.31-409.34.

202. Intermediate Care Facility/Intellectual Disability (ICF/ID)

- 202.1. ICF/ID level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with intellectual disabilities or related conditions.
- 202.2. An ICF/ID level of care is indicated if one or more conditions under the ICF/ID Level of Care Criteria, in Appendix F, are met. Conditions are derived from 42 C.F.R. 440.150, 435.1009 and 483.440(a).

203. Hospital

- 203.1. Hospital level of care is appropriate for individuals who continuously require the type of care ordinarily provided in an institution for the care and treatment of inpatients with disorders other than mental diseases.
- 203.2. A hospital level of care is indicated if all the conditions of Column A, Column B, and Column C are satisfied. Conditions derived from 42 C.F.R 440.10.
- 203.3. As derived from 42 C.F.R. 440.10, the child requires the type of care ordinarily furnished in a hospital for the care and treatment of inpatients, other than that for mental diseases, under the direction of a physician or dentist. Hospital level of care screen: This is a new responsibility as far as Katie Beckett is concerned. Alliant will determine

if the clinical information provided meets Pediatric InterQual criteria. (Rev. 04/2025)
The responsibility is identical to the pre-certification process on behalf of adults. The review is to be done at the time of the initial application, and for children who qualified by meeting the hospital level of care, every thirty (30) days thereafter.

204. Level of Care Determination Routing Form

The Level of Care Determination Routing Form 705 must accompany all the child's information and documents submitted to AHS. It is imperative that identifying information such as Social Security number and Medicaid identification remain consistent whenever communicating with AHS to ensure adequate tracking for the child's case.

205. Cost-Effectiveness Determination

The estimated Medicaid cost of caring for the child outside the institution must not exceed the estimated Medicaid cost of appropriate institutional care. The Physician's Referral Form has been replaced with the TEFRA/Katie Beckett Cost-Effectiveness Form-704. The revised form includes places for the physician to include the estimated cost for therapy(s) and skilled nursing services and will assist the Department in establishing a process for providing the actual cost of services provided to a child that will be used during the periodic redetermination. However, until the process has been established, workers will continue to use the TEFRA/Katie Beckett Cost-Effectiveness Form-704 at the time of initial application and the periodic redetermination of eligibility to complete the cost-effectiveness determination.

The amounts listed below are the averaged amounts to be used for completion of the nursing facility and ICF/ID level-of-care cost-effectiveness determination.

Level-of-Care	Monthly Amount (average Medicaid rates)
Skilled Nursing Facility	\$ 8,133.00 (31 days)
ICF/ID	\$ 36,577.00 (31 days)

Chapter 300: Hearing and Appeals Process

301. Hearing and Appeal Process

Due process rights associated with the denial of admission to the “Katie Beckett” program begin after the level of care assessment and disability assessment by AHS. Participants in the “Katie Beckett” program are subject to periodic assessments by AHS. Should the level of care assessment or disability assessment result in the denial of admission/continuation into the Katie Beckett program, AHS will forward an “Initial Denial of Admission/Continued Stay” to the family (with a copy to the KB Medicaid Specialist). This notice informs the parents of the reason for the denial and their administrative review rights.

The Department offers the opportunity for administrative review to any applicant or recipient against whom it proposes to take an adverse action, unless otherwise authorized by law to take such action without having to do so. Parents may request an administrative review of the level of care assessment and/or the disability assessment within thirty (30) days “Initial Denial of Admission/Continued Stay.” The request must include all relevant issues in controversy and must be accompanied by any additional medical information and explanation that the applicant or recipient wishes the Department to consider. The additional documentation will be considered to determine the appropriateness of the initial denial. Alliant Health Solutions personnel should instruct parents to supply the additional documentation to AHS for consideration during the administrative review process. If the parent fails to request an administrative review or if the parent fails to submit additional documentation, the initial denial will become final on the 30th day after the date of the “Initial Denial of Admission/Continued Stay” notification.

Alliant Health Solutions must receive requests for administrative review within the 30- day time limit. When counting days, allow the parents a two (2) daytime period for receipt of the letter. Then, beginning on the third day after the date of the letter, regardless of whether that day is a weekend or holiday, count thirty (30) days. However, if the 30th day falls on a weekend or holiday, the next full business day is counted as the 30th day.

Upon completion of the Administrative Review, AHS will notify the parents of the results of the review, with a copy to the KB Medicaid Specialist. Should AHS uphold the initial decision, and the family fails to request an administrative review or fails to submit additional documentation, then a “Final Denial of Admission/Continued Stay” letter is sent to the parents with a copy to the KB Medicaid Specialist. This notice informs the parents of the reason for the denial and their hearing rights. The Legal Services Section of DCH must receive a parent’s request for a hearing (and continuation of services, if applicable) before an administrative law judge within thirty (30) days of the date of the “Final Denial of Admission/Continued Stay” letter. The hearing request must state the specific reasons for requesting the hearing. Parents must also state whether they would like a continuation of services pending the outcome of the hearing. This option is only available for those members requesting continued stay in the program. However, these members must be cautioned that should the Department prevail, the Department may seek reimbursement for services rendered during the appeals period. Additionally, parents must include a copy of the “Final Denial of Admission/Continued Stay” letter with their hearing request.

After receiving the hearing request, Legal Services will e-mail a request for documentation to AHS. Legal Services will also notify the Eligibility Section of a parent’s request for a continuation of

services. Upon receiving the file from AHS, Legal Services will prepare the file to be assigned to an attorney and forward the appropriate documentation to the Office of State Administrative Hearings for scheduling. Files submitted to Legal Services must contain, among other things, DMA-6(A), any additional documents submitted during the administrative review process, the initial and final determination letters, the parent's hearing request, the contact information for the KB Medicaid Specialist and the contact information for the AHS assessor. The AHS assessor will work with the DCH attorney to prepare for the hearing. If the denial of eligibility issued by the KB Team is solely based upon the level of care determination, the DCH Policy Specialist will be required to testify regarding the denial of eligibility determination. This will prevent the need for two hearings, since the denial of eligibility and the level of care determination are intertwined.

If the administrative review decision is upheld at the hearing, the parents will be notified, and a copy will be sent to the KB Medicaid Specialist. The decision will include a ruling on the denial of eligibility, if the denial was based solely upon the level of care determination and/or disability determination. The KB Medicaid Specialist will send notice to parents of the denial of eligibility and close the case. The decision from the Administrative Law Judge will include appeal rights for any party dissatisfied with the decision. If the Administrative Law Judge determines that the level of care criteria and/or disability criteria have been met, a written decision will be forwarded to the parent, with a copy to the KB Medicaid Specialist. At this time, the KB Medicaid Specialist will use the level of care and/or disability determinations with other information to render an eligibility decision.

A denial of eligibility based upon factors not associated with the level of care or disability will create additional due process rights. However, these hearings are handled by the Department of Human Services/Right from The Start Medicaid Project and may occur after or concurrent with the level of care hearings. The timing of these hearings is based upon the timing of the decision on eligibility.

302. Notice of Your Right to a Hearing



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

NOTICE OF YOUR RIGHT TO A HEARING

You have the right to a hearing regarding this decision. To have a hearing, you must ask for one **in writing**. You must send your request for a hearing, along with a copy of the adverse action letter, within **thirty (30) days** of the date of the letter to:

**Georgia Department of Community Health
Office of General Counsel -Legal Services
2 Martin Luther King Jr. Dr. SE, East Tower 18th FL
Atlanta, GA 30334**

If you want to maintain your services pending the hearing decision, you must send a written request **before** the date your services change. **If the denial is upheld by a hearing decision, you may be held responsible for the repayment of continued services that were provided during the appeal.**

The Office of State Administrative Hearings will notify you of the time, place and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourself or let a friend or family member to speak for you. You also may ask a lawyer to represent you. You may be able to obtain legal help at no cost. If you desire an attorney to help you, you may call one of the following telephone numbers:

1. Georgia Legal Services Program

1-800-498-9469

(Statewide legal services, EXCEPT for the
counties served by Atlanta Legal Aid)

2. Georgia Advocacy Office

1-800-537-2329

(Statewide advocacy for persons with
Disabilities or mental illness)

3. Atlanta Legal Aid 4. State Ombudsman Office

404 377-0701 (DeKalb/Gwinnett counties)

770-528-2565 (Cobb County)

404-524-5811 (Fulton County)

404-669-0233 (So. Fulton/Clayton counties)

678-376-4545 (Gwinnett County)

4. State Ombudsman Office

1-888-454-5826

(Nursing Home or Personal Care Home)

303. Member Review Process

303.1. Part I Policies and Procedures for Medicaid/Peachcare for Kids

303.1.1. Please see Part I manual for Member Review Process on the Medicaid Member Administrative Law Hearings (Fair Hearings)

304. Technical Denials

304.1. Treatment of Technical Denials

304.1.1. Please see Part I manual for Member Review Process on Treatment of Technical Denials.

Appendix A
TEFRA/Katie Beckett Level-of-Care and Disability Determination Routing Form/Checklist

DATE SENT: _____

TO: **Alliant Health Solutions (AHS)**
 ATTN: TEFRA/Katie Beckett
 P.O. Box 105406
 Atlanta, Georgia 30348-5406

From: **Katie Beckett Medicaid Team**

Medicaid Specialist's Name: _____ Direct Phone #: _____

Medicaid Specialist's E-mail Address: _____

Medicaid Specialist's Mailing Address: _____

RE: Applicant's Name: _____

Applicant's Address: _____

Applicant's SSN: _____

Parent/Guardian Name: _____

Physician Name: _____

A complete packet must be submitted to AHS for a review the Level of Care Determination review. A complete packet consists of the following with:

_____ DMA-6(A)*

_____ TEFRA/Katie Beckett Medical Necessity/Level of Care Statement*

_____ Psychological, IQ test or Adaptive Functioning Evaluation -- only required for children with intellectual disabilities or related conditions such as Cerebral Palsy, Epilepsy, Autism, Autism-Spectrum Disorder, Asperger Syndrome, Down's Syndrome, Pervasive Developmental Disorder or other Developmental Delays (required with initial application for ICF/ID determinations and again every three years)

_____ IEP or IFSP if one is in effect*

_____ Rehab Therapy/Nursing Notes (if applicable)

* Required for all level of care determinations

DMA 705
(Rev 01/2025)

Appendix B
TEFRA/Katie Beckett Medical Necessity/Level of Care Statement

Member Name: _____ DOB: _____ SS#: _____

Diagnosis: _____

Recommended level of Care:

- ☐ Nursing facility level of care
- ☐ Hospital 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):

		<u>Current Needs</u>
	None	Description of Skilled Nursing Needs
Cardiovascular:	_____	_____
Neurological:	_____	_____
Respiration	_____	_____
Nutrition:	_____	_____
Integumentary:	_____	_____
Urogenital:	_____	_____
Bowel:	_____	_____
Endocrine:	_____	_____
Immune:	_____	_____
Skeletal:	_____	_____
Other:	_____	_____

Therapy (Attach current notes): Speech sessions/wk _____ PT sessions/wk _____ OT sessions/wk _____
Autism Spectrum Services/wk _____

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: ____ No ____ Yes (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, hospital, or facility whose primary purpose is to furnish health and rehabilitative services to persons with intellectual disabilities or related conditions.

Physician's Signature: _____ Date: _____

Primary Caregiver/Parent/Guardian Signature: _____ Date: _____

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

(DMA 706)

(Rev. 05/2025)

Appendix B-1
TEFRA/Katie Beckett Medical Necessity/Level of Care Statement

A. TEFRA/Katie Beckett Medical Necessity/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.

i. Member (Applicant) Information

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

ii. Diagnosis

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

iii. Level of Care

Check the correct box for the recommended level of care.

iv. Medical History

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

v. Current Needs

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

vi. 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.

vii. Hospitalizations

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

viii. School

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

ix. 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.

Appendix C
Cost-Effectiveness Form (Child's Physician Must Complete Form)

The following information is requested to determine your patient's eligibility for Medicaid:

Patient's Name: _____ Medicaid #: _____

Diagnosis: _____

Prognosis: _____

Please provide the estimated **monthly** costs of Medicaid services your patient will need or is seeking from Medicaid for in-home care:

- Physician's services \$ _____
- Durable medical equipment \$ _____
- Drugs \$ _____
- Therapy(s) \$ _____
- Skilled nursing services \$ _____
- Other(s) _____ \$ _____

TOTAL: \$ _____

Will home care be as good as or better than institutional care? _____ Yes _____ No

Comments: _____

Physician's signature: _____

Date: _____

Appendix D
Initial Determination Letter



DATE:

Member Name

Member Address

Member Address

TEFRA/KATIE BECKETT INITIAL DETERMINATION LETTER

☐ LEVEL OF CARE DENIAL (LOC)

☐ TECHNICAL DENIAL

MEMBER:

MEDICAID ID:

PAID:

Dear Parent/Legal Guardian:

To receive TEFRA/Katie Beckett coverage under the Georgia Medicaid program, the child's medical condition must require the level of care (LOC) provided in a nursing facility, hospital, or if the child is intellectually disabled, he/she must meet criteria for placement in an intermediate care facility ("ICF/ID"). See 42 C.F.R. § 435.225(b)(1); 409.31-409.34; 440.150; 435.1010; and 483.440(a).

Alliant Health Solutions, on behalf of the Department of Community Health (DCH), makes the level of care determination based on the information submitted. The child's name listed above does not meet criteria for the TEFRA/Katie Beckett Class of Eligibility for the following reasons:

☐ Applicant does not meet the criteria of:

☐ Nursing Facility LOC- Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or other health-related services *ordinarily provided in an institution*.

☐ Hospital LOC- Hospital level of care is appropriate for individuals who continuously require the type of care ordinarily provided in an institution for the care and treatment of inpatients with disorders other than mental diseases.

☐ ICF/ID LOC- ICF/ID level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with an intellectual disability or related conditions.

☐ Although the physician has recommended Nursing Facility Level of Care, he/she has not ordered the level of skilled services required to meet criteria under this level of care which is a requirement of 42 C.F.R. §.409.31 – 409.34.

☐ Although the physician ordered skilled services, documentation submitted does not

demonstrate this level of services presently in place which is requirement of 42 C.F.R. § 409.31-409.34.

- ☐ Rehabilitative services are not required five (5) days per week or skilled nursing services seven (7) days per week per the documentation submitted which is a requirement of 42 C.F.R. § 409.31-409.34.
- ☐ This child has a diagnosis of intellectual disability or a condition that is closely related to intellectual disability, but the psychological/developmental evaluation scores do not meet the Level of Care criteria. This is a requirement of 42 C.F.R. § 440.150, 435.1010 and 483.440(a).
- ☐ You failed to submit all the required documents for review. The following documents were missing from the packet:
 - ☐ Complete Pediatric DMA-6A (Physicians Recommendation for Pediatric Care)
 - ☐ Complete TEFRA/Katie Beckett Medical Necessity/Level of Care Statement
 - ☐ Individualized Family Service Plan (IFSP)
 - ☐ Individualized Education Plan (IEP)
 - ☐ Comprehensive Developmental (ages 0-5 years) or Psychological (age 6 and up) Evaluation (required within the last 3 years for initial application for ICF/ID determinations and every three years thereafter)
 - ☐ Private Rehabilitative Therapy Notes (occupational/ physical/speech therapy, or autism spectrum disorder services)
 - ☐ School Based Rehabilitative Therapy Notes (occupational, physical, speech therapy, or autism spectrum disorder services)
 - ☐ Skilled Nursing Notes
 - ☐ Other
- ☐ The physician failed to certify the applicant requires the level of care provided by a nursing facility, hospital or ICF/ID facility (see Item 25 of DMA 6(A) form).
- ☐ Reviewers Comments:

In accordance with the 42 C.F.R. 435.225, your request for long-term care services under the Georgia Medicaid program will be denied unless additional medical information for the LOC denial can justify the need for institutional care. Attached is a copy of the Level of Care Criteria used for this determination for your review. Likewise, if the determination was a technical denial, all missing information must be submitted in order to make a level of care determination.

If you disagree with this initial determination, you may request a Reconsideration Review or request a hearing. You may obtain a Reconsideration Review of this decision by sending additional clinical information from your child's physician within thirty (30) calendar days of the date of this letter to:

Alliant Health Solutions
Attention: TEFRA/Katie Beckett Review Nurse
P.O. Box 105406 Atlanta, Georgia 30348
Fax number: 678-527-3001

Please contact the *Right From the Start Katie Beckett Team*, attending physician, or your original referring agency if you need help with your request. Once the Department has received the additional information, it will be reviewed, and a Final Determination Letter will be issued regarding your child's level of care determination.

If additional medical information is not received within thirty (30) calendar days from the date of this letter, the decision will become FINAL. You do not lose your right to a fair hearing if you choose to have a Reconsideration Review completed. You have thirty (30) calendar days from the date of this letter to request a hearing in writing to the following address:

**Georgia Department of Community Health
Office of General Counsel -Legal Services
2 Martin Luther King Jr. Dr. SE, East Tower 18th FL
Atlanta, GA 30334**

Sincerely,

TEFRA/Katie Beckett Review Team

Appendix E
Final Determination Letter



DATE:

Member Name

Member Address

Member Address

TEFRA/KATIE BECKETT FINAL DETERMINATION LETTER

☐ LEVEL OF CARE DENIAL (LOC)

☐ TECHNICAL DENIAL

MEMBER:

MEDICAID ID:

PA ID:

Dear Parent/Legal Guardian:

To receive TEFRA/Katie Beckett coverage under the Georgia Medicaid program, the child's medical condition must require the level of care (LOC) provided in a nursing facility or hospital, or if the child is intellectually disabled, he/she must meet criteria for placement in an intermediate care facility ("ICF/ID"). See 42 C.F.R. § 435.225(b)(1); 409.31-409.34; 440.150; 435.1010; and 483.440(a).

Alliant Health Solutions, on behalf of the Georgia Department of Community Health (DCH), has:

reviewed the **new supplementary medical information submitted by you** or

not received any additional medical information from you.

Alliant Health Solutions, on behalf of the Department of Community Health (DCH), makes the level of care determination based on the documentation submitted. The child's name listed above does not meet criteria for the TEFRA/Katie Beckett Class of Eligibility for the following reasons:

☐ Applicant does not meet the criteria of:

☐ Nursing Facility LOC- Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or other health-related services *ordinarily provided in an institution*.

☐ Hospital LOC- Hospital level of care is appropriate for individuals who continuously require the type of care ordinarily provided in an institution for the care and treatment of inpatients with disorders other than mental diseases.

- ☐ ICF/ID LOC- ICF/ID level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with an intellectual disability or related conditions.
- ☐ Although the physician has recommended Nursing Facility Level of Care, he/she has not ordered the level of skilled services required to meet criteria under this level of care which is a requirement of 42 C.F.R. § 409.31-409.34.
- ☐ Although the physician ordered skilled services, documentation submitted does not demonstrate that this level of services is presently in place which is a requirement of 42 C.F.R. § 409.31-409.34.
- ☐ Rehabilitative services are not required five (5) days per week or skilled nursing services seven (7) days per week per the documentation submitted which is a requirement of 42 C.F.R. § 409.31- 409.34.
- ☐ This child has a diagnosis of intellectual disability, or a condition that is closely related to intellectual disability, but the psychological/developmental evaluation scores do not meet the Level of Care criteria. This is a requirement of 42 C.F.R. §440.150, 435.1010 and 483.440(a).
- ☐ You failed to submit all the required documents for review. The following documents were missing from the packet:
 - ☐ Complete Pediatric DMA-6A (Physicians Recommendation for Pediatric Care)
 - ☐ Complete TEFRA/Katie Beckett Medical Necessity/Level of Care Statement
 - ☐ Individualized Family Service Plan (IFSP)
 - ☐ Individualized Education Plan (IEP)
 - ☐ Comprehensive Developmental (ages 0-5 years) or Psychological (age 6 and up) Evaluation (required within the last 3 years for initial application for ICF/ID determinations and every three years thereafter)
 - ☐ Private Rehabilitative Therapy Notes (occupational, physical, speech therapy, or autism spectrum disorder services)
 - ☐ School Based Rehabilitative Therapy Notes (occupational, physical, speech therapy, or autism spectrum disorder services)
 - ☐ Skilled Nursing Notes
 - ☐ Other
- ☐ The physician failed to certify the applicant requires the level of care provided by a nursing facility, hospital or ICF/ID facility (see Item 25 of DMA 6(A) form).
- ☐ Reviewers Comments:

In accordance with 42 CFR § 435.225, your request for long-term services under the Georgia Medicaid program is denied. If you disagree with this denial, you may request a fair hearing. To have a hearing, you must ask for one in writing. Your request for hearing must be *received* by the Department of Community Health within thirty (30) days of the date of this letter. An explanation of your hearing rights is attached.

If you are currently receiving services, you may also request that the Department maintain your services at the current level pending the outcome of your hearing. If the Administrative Law Judge rules in favor of the

Department, the Department may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient.

If you are challenging the Department's level of care determination, please send your written request for hearing to:

Georgia Department of Community Health
Office of General Counsel -Legal Services
2 Martin Luther King Jr. Dr. SE, East Tower 18th FL
Atlanta, GA 30334

Please attach this letter to your request for a hearing. If you are requesting a hearing for any reason other than for the level of care determination, please send your written request to your local RSM/KB Team.

Finally, if your child's condition changes significantly (i.e., major surgery occurrence, progression/relapse of disease, etc.) or you have current information that you would like the agency to consider, you may reapply.

Sincerely,

TEFRA/Katie Beckett Review Team

Appendix F
Final Determination Approval Letter



DATE:

Member Name
Member Address
Member Address

TEFRA/KATIE BECKETT FINAL DETERMINATION APPROVAL LETTER

MEMBER:
MEDICAID ID:
PA ID:

Dear Parent/Legal Guardian:

To receive TEFRA/Katie Beckett coverage under the Georgia Medicaid program, the child's medical condition must require the level of care (LOC) provided in a nursing facility, hospital, or if the child is intellectually disabled, he/she must meet criteria for placement in an intermediate care facility ("ICF/ID"). See 42 C.F.R. § 435.225(b)(1); 409.31-409.34; 440.150; 435.1010; and 483.440(a).

This letter is to notify you that based on our evaluation, the applicant meets the level of care and disability criteria for TEFRA/ Katie Beckett approval.

Sincerely,

TEFRA/Katie Beckett Review Nurse

Appendix G

Pediatric Nursing Facility Level of Care

A. Nursing Facility Level of Care

Level of care criteria are based on definitions and guidelines derived from the Federal regulations in 42 C.F.R 409.31-409.34 and are used to assist assessors in evaluating clinical information submitted. Level of care criteria are based on the overall medical condition of the individual and the medically necessary services required. Level of care is not diagnosis specific.

i. Summary:

Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or other health-related services *ordinarily provided in an institution*. With respect to an individual who has a mental illness or intellectual disability, nursing facility level of care services are usually inappropriate unless that individual's mental health needs are secondary to needs associated with a more acute physical disorder.

1. A nursing facility level of care is indicated if all of following conditions are met Services received in an educational setting must meet these same conditions. The service(s) has been ordered by a physician.

- (a) The service(s) will be furnished either directly by, or under the direct supervision of, appropriately licensed personnel.
- (b) The individual requires service(s) which are so inherently complex that it can be safely and effectively performed only by, or under the supervision of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, speech pathologists or audiologists; and autism service qualified health care providers; and
- (c) The individual requires either skilled nursing services seven days per week or skilled rehabilitation services at least five days per week.

Appendix G-1
Hospital Level of Care

B. Level of Care

Level of care criteria are based on definitions and guidelines derived from the Federal regulations 42 C.F.R 440.10 and are used to assist assessors in evaluating clinical information submitted. Level of care criteria are based on the overall medical condition of the individual and medically necessary services and is not diagnosis specific.

i. Summary:

Hospital level of care is appropriate for individuals who continuously require the type of care ordinarily provided in an institution for the care and treatment of inpatients with disorders other than mental diseases.

1. A hospital level of care is indicated if the conditions are met:

- (a) The service needed has been ordered by a physician or dentist.
- (b) The service will be furnished either directly by, or under the direct supervision of, a physician or dentist.
- (c) The individual's condition meets inpatient level of care.
- (d) The individual has a condition for which room, board, and professional services furnished under the direction of a physician or dentist is expected to be medically necessary for a period of 48 hours or longer.

Appendix G-2

Intermediate Care Facility (ICF/ID) Level of Care

A. Intermediate Care Facility (ICF/ID) Level of Care

Level of care criteria are based on definitions and guidelines derived from the Federal regulations, 42 C.F.R. 440.150, 435.1009, and 483.440(a) and are used to assist assessors in evaluating clinical information submitted. Level of care criteria are based on the overall medical condition of the individual and the medically necessary service required and is not diagnosis specific.

ii. Summary:

ICF/ID level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with intellectual disabilities or related conditions.

1. An ICF/ID level of care is generally indicated if any of the following conditions are met:

- (a) The child has an IQ of 70 or below (moderate to profound intellectual disability); or
- (b) The child has a standard score of 70 or below in at least three of the five domains of function (cognitive, language, motor, social-emotional, and adaptive) on a standardized developmental assessment tool or an overall standard score of 70 or below; or
- (c) The child has a standard score of 70 or below in at least three domains of function on a standardized adaptive functioning assessment tool or an overall composite score of 70 or below; or
- (d) The child's Childhood Autism Rating Scale (CARS) score is 37 or greater, or the Gilliam Autism Rating Scale (GARS) score is 101 or greater.

Note: An age appropriate, comprehensive functional assessment is required at least every three years. For children 0-5 years of age, a comprehensive developmental evaluation is required. For children 6-18 years of age, a comprehensive psychological evaluation is required.

Appendix H
Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

A. Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

For information on the Georgia Families, Georgia Families 360, or Non-Emergency Medical Transportation program, please access the overview document at the following link:

- iii. **Georgia Families 360 Overview:**
[https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/
tabId/18/Default.aspx](https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx)
- iv. **Non-Emergency Medical Transportation Overview:**
[https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/
tabId/18/Default.aspx](https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx)

Appendix I

Pediatric DMA 6(A)

Type of Program:

☐ Nursing Facility
☐ TEFRA/Katie Beckett

☐ GAPP
☐ ICF/ID

PEDIATRIC DMA 6(A)

PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

Section A – Identifying Information					
1. Applicant's Name/Address: DFCS County _____ _____ Mailing Address _____	2. Medicaid Number: _____	3. Social Security Number _____			
		4. Sex _____	Age _____	4A. Birthdate _____	
	5. Primary Care Physician _____				
	6. Applicant's Telephone # _____				
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: _____ Name of Caregiver #2: _____ 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)					
13. Diagnosis 1) _____ 2) _____ 3) _____ (Add attachment for additional diagnoses)		1. ICD _____	2. ICD _____	3. ICD _____	
14. Medications		15. Diagnostic and Treatment Procedures			
Name	Dosage	Route	Frequency	Type	Frequency
16. Treatment Plan (Attach copy of order sheet if more convenient or other pertinent documents) Previous Hospitalizations: _____ Rehabilitative/Habilitative Services: _____ Other Health Services: _____					

Hospital Diagnosis: 1) _____ 2) Secondary _____ 3) Other _____			
17. Anticipated Dates of Hospitalization: _____ / _____		18. Level of Care Recommended: ☐ Hospital ☐ Nursing Facility ☐ ICF/ID Facility ☐	
19. Type of Recommendation: ☐ Initial ☐ Change Level Care ☐ Continued Placement	20. Patient Transferred from (check one): ☐ Hospital ☐ Private Pay ☐ Another NF ☐ 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):	
		Physician's Address (Print):	
25. I certify that this patient requires the level of care provided by a hospital, nursing facility, or ICF/ID Physician's Signature:	26. Date signed by Physician	27. Physician's Licensure No.	28. Physician's Telephone #: ()

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

29. Nutrition ☐ Regular ☐ Diabetic Shots ☐ Formula-Special ☐ Tube feeding ☐ N/G-tube/G-tube ☐ Slow Feeder ☐ FTT or Premature ☐ Hyperal ☐ IV Use ☐ Medications/ GT Meds	30. Bowel ☐ Age Dependent ☐ Incontinence ☐ Incontinent - Age >3 ☐ Colostomy ☐ Continent ☐ Other	31. Cardiopulmonary Status ☐ 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	32. Mobility ☐ Prosthesis ☐ Splints ☐ Unable to ambulate > 18 months old ☐ Wheelchair ☐ Normal	33. Behavioral Status ☐ Agitated ☐ Cooperative ☐ Alert ☐ Developmental Delay ☐ Mental Retardation ☐ Behavioral Problems ☐ (please describe, if checked) ☐ Suicidal ☐ Hostile
34. Integument System ☐ Burn Care ☐ Sterile Dressings ☐ Decubiti ☐ Bedridden ☐ Eczema-severe ☐ Normal	35. Urogenital ☐ Dialysis in home ☐ Ostomy ☐ Incontinent – Age >3 ☐ Catheterization ☐ Continent	36. Surgery ☐ Level 1 (5 or > surgeries) ☐ Level II (< 5 surgeries) ☐ None	37. Therapy/Visits ☐ 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	38. Neurological Status ☐ Deaf ☐ Blind ☐ Seizures ☐ Neurological Deficits ☐ Paralysis ☐ Normal
39. Other Therapy Visits Five days per week ☐ Less than 5 days per week ☐		40. Remarks 		
41. Pre-Admission Certification Number		42. Date Signed	43. Print Name of MD or RN: _____ 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 ☐	

Appendix I-1

6Ai Instructions for Form DMA-6(A): Physician's Recommendation for Pediatric Care

Instructions: It is important that EVERY item on the DMA-6(A) is answered, even if it is answered as N/A (not applicable). Make sure that the physician or nurse who completes some of the sections is aware of this requirement. The form is only valid for 90 days from the date of the physician's signature. The form should be completed as follows:

Section A – Identifying Information	
Section A of the form should be completed by the parent or the legal representative of the Katie Beckett child unless otherwise noted. All reference to “the applicant” means the child for whom Medicaid is being applied for.	
Item #	Instructions
Item 1: Applicant's Name/Address	Enter the complete name and address of the applicant including the city and ZIP code. For DFCS County enter the applicant's county of residence.
Item 2: Medicaid Number	To be completed by county staff.
Item 3: Social Security Number	Enter the applicant's nine-digit Social Security number.
Item 4 & 4A: Sex, Age and Birthdate	Enter the applicant's sex, age, and date of birth.
Item 5: Primary Care Physician	Enter the entire name of the applicant's Primary Care Physician.
Item 6: Applicant's Telephone Number	Enter the telephone number, including area code, of the applicant's parent or the legal representative.
Item 7: Does guardian think the applicant should be institutionalized?	If the Katie Beckett applicant were not eligible under this category of Medicaid, would s/he be appropriate for placement in a nursing facility or institution for the intellectually disabled. Check the appropriate box.
Item 8: Does the child attend school?	Check the appropriate box.
Item 9: Date of Medicaid Application	To be completed by county staff.
Fields below Item 9:	Please enter the name of the primary caregiver for the applicant. If a secondary caregiver is available to care for the applicant, include the name of the caregiver.
Item 10: Signature	Read the statement below the name(s) of the caregiver(s), and then, the parent or legal representative for the applicant should sign the DMA-6(A) legibly.
Item 11: Date	Please record the date the DMA-6 (A) was signed by the parent or the legal representative.

Section B - Physician's Examination Report and Recommendation

This section must be completed in its entirety by the Katie Beckett child's **Primary Care Physician**. No item should be left blank unless indicated below.

Item 12: History	Attach additional sheet(s) if needed. Describe the applicant's medical history (Hospital records may be attached).
Item 13: Diagnosis	Add attachment(s) for additional diagnoses. Describe the primary, secondary, and any third diagnoses relevant to the applicant's condition on the appropriate lines. Please note the ICD codes. Depending on the diagnosis, a psychological evaluation may be required. If you have an evaluation conducted within the past three years, include a copy with this packet.
Item 13A: ICD-10 Diagnosis Code	Add attachment(s) for additional diagnoses. Describe the primary, secondary, and any third ICD-10 diagnoses relevant to the applicant's condition on the appropriate lines.
Item 14: Medications	Add attachment(s) for additional medication(s). The name of all medications the applicant is to receive must be listed. Include name of drugs with dosages, routes, and frequencies of administration.
Item 15: Diagnostic and Treatment Procedures	Include all diagnostic or treatment procedures and frequencies.

Item 16: Treatment Plan	Attach copy of order sheet if more convenient or other pertinent documentation. List previous hospitalization dates, as well as rehabilitative and other health care services the applicant has received or is currently receiving. The hospital admitting diagnoses (primary, secondary, and other diagnoses) and dates of admission and discharge must be recorded. The treatment plan may also include other pertinent documents to assist with the evaluation of the applicant.
Item 17: Anticipated Dates of Hospitalization	List any anticipated dates of hospitalization for the applicant. Enter N/A if not applicable.
Item 18: Level of Care Recommended	Check the correct box for the recommended level of care; nursing facility, hospital, or intermediate care facility for the intellectually disabled. If left blank or N/A is entered, it is assumed that the physician does not deem this applicant appropriate for institutional care.
Item 19: Type of Recommendation	Indicate if this is an initial recommendation for services, a change in the member's level of care, or a continued placement review for the member.
Item 20: Patient Transferred From	Check one. Indicate if the applicant was transferred from a hospital, private pay, another nursing facility or lives at home.
Item 21: Length of Time Care Needed	Enter the length of time the applicant will require care and services from the Medicaid program. Check the appropriate box for permanent or temporary. If temporary, please provide an estimate of the length of time care will be needed.
Item 22: Is Patient Free of Communicable Diseases?	Check the appropriate box.
Item 23: Alternatives to Nursing Facility Placement	The admitting or attending physician must indicate whether the applicant's condition could be managed by provision of the Community Care or Home Health Care Services Programs. Check either/both the box(es) corresponding to Community Care and/or Home Health Services if either/or both is appropriate.
Item 24: Physician's Name and Address	Print the admitting or attending physician's name and address in the spaces provided.
Item 25: Certification Statement of the Physician and Signature	The admitting or attending physician must certify that the applicant requires the level of care provided by a hospital, nursing facility or an intermediate care facility for the intellectually disabled. This must be an original signature; signature stamps are not acceptable. If the physician does not deem this applicant appropriate for institutional care, enter N/A and sign.
Item 26: Date Signed by the Physician	Enter the date the physician signs the form.
Item 27: Physician's Licensure Number	Enter the attending or admitting physician's license number.
Item 28: Physician's	Enter the attending or admitting physician's telephone number including area

Telephone Number	code.
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Section C - Evaluation of Nursing Care Needed

Check appropriate boxes only. This section may be completed by the Katie Beckett child's **Primary Care Physician or a registered nurse** who is well aware of the child's condition.

Items 29 - 38	Check each appropriate box.
Item 39: Other Therapy Visits	If applicable, check the appropriate box for the number of treatment or therapy sessions per week the applicant receives or needs. Enter N/A, if not applicable.
Item 40: Remarks	Enter additional remarks if needed or "None".
Item 41: Pre-admission Certification Number	Leave this item blank.
Item 42: Date Signed	Enter the date this section of the form is completed.
Item 43: Print Name of MD or RN/Signature of MD or RN	The individual completing Section C should print their name legibly and sign the DMA-6(A). This must be an original signature; signature stamps are not acceptable.
Items 44 - 52	Do Not Write Below This Line. Items 44 through 52 are completed by Contractor staff only.