

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

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

<b>Section A – Identifying Information</b>			
1. Applicant's Name/Address:   DFCS County _____  Mailing Address _____		2. Medicaid Number: _____	
		3. Social Security Number _____	
		4. Sex	Age
		5. Primary Care Physician _____	
		6. Applicant's Telephone # _____	
7. Does guardian think the applicant should be institutionalized? <input type="checkbox"/> Yes <input type="checkbox"/> No		8. Does child attend school? <input type="checkbox"/> Yes <input type="checkbox"/> 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)			
<b>Section B – Physician's Report and Recommendation</b>			
12. History: (attach additional sheet if needed)			
13. Diagnosis 1) _____ 2) _____ 3) _____ (Add attachment for additional diagnoses)		1. ICD	2. ICD
		3. ICD	
<b>14. Medications</b>		<b>15. Diagnostic and Treatment Procedures</b>	
Name	Dosage	Route	Frequency
16. Treatment Plan (Attach copy of order sheet if more convenient or other pertinent documents)			
Previous Hospitalizations: _____ Rehabilitative Services: _____ Other Health Services: _____			
Hospital Diagnosis: 1) _____ 2) Secondary _____ 3) Other _____			
17. Anticipated Dates of Hospitalization: _____ / _____		18. Level of Care Recommended: <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility <input type="checkbox"/> IC/MR Facility	
19. Type of Recommendation: <input type="checkbox"/> Initial <input type="checkbox"/> Change Level of Care <input type="checkbox"/> Continued Placement		20. Patient Transferred from (check one): <input type="checkbox"/> Hospital <input type="checkbox"/> Another NF <input type="checkbox"/> Private Pay <input type="checkbox"/> Lives at home	
		21. Length of Time Care Needed _____ Months 1) <input type="checkbox"/> Permanent 2) <input type="checkbox"/> Temporary _____ estimated	
22. Is patient free of communicable diseases? <input type="checkbox"/> Yes <input type="checkbox"/> No			
23. This patient's condition <input type="checkbox"/> could <input type="checkbox"/> could not be managed by provision of <input type="checkbox"/> Community Care or <input type="checkbox"/> 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 nursing facility, IC/MR facility, or hospital Physician's Signature _____		26. Date signed by Physician	27. Physician's Licensure No.
		28. Physician's Telephone #: (   )	
<b>Section C – Evaluation of Nursing Care Needed (check appropriate box only)</b>			
29. Nutrition	30. Bowel	31. Cardiopulmonary Status	32. Mobility
<input type="checkbox"/> Regular <input type="checkbox"/> Diabetic Shots <input type="checkbox"/> Formula-Special <input type="checkbox"/> Tube feeding <input type="checkbox"/> N/G-tube/G-tube <input type="checkbox"/> Slow Feeder <input type="checkbox"/> FTT or Premature <input type="checkbox"/> Hyperal <input type="checkbox"/> IV Use <input type="checkbox"/> Medications/GT Meds	<input type="checkbox"/> Age Dependent Incontinence <input type="checkbox"/> Incontinent - Age > 3 years <input type="checkbox"/> Colostomy <input type="checkbox"/> Continent <input type="checkbox"/> Other _____	<input type="checkbox"/> Monitoring <input type="checkbox"/> CPAP/Bi-PAP) <input type="checkbox"/> CP Monitor <input type="checkbox"/> Pulse Ox <input type="checkbox"/> Vital signs > 2/days <input type="checkbox"/> Therapy <input type="checkbox"/> Oxygen <input type="checkbox"/> Home Vent <input type="checkbox"/> Trach <input type="checkbox"/> Nebulizer Tx <input type="checkbox"/> Suctioning <input type="checkbox"/> Chest - Physical Tx <input type="checkbox"/> Room Air	<input type="checkbox"/> Prosthesis <input type="checkbox"/> Splints <input type="checkbox"/> Unable to ambulate > 18 months old <input type="checkbox"/> Wheel chair <input type="checkbox"/> Normal
33. Behavioral Status			
<input type="checkbox"/> Agitated <input type="checkbox"/> Cooperative <input type="checkbox"/> Alert <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Behavioral Problems (please describe, if checked) <input type="checkbox"/> Suicidal <input type="checkbox"/> Hostile			
34. Integument System	35. Urogenital	36. Surgery	37. Therapy/Visits
<input type="checkbox"/> Burn Care <input type="checkbox"/> Sterile Dressings <input type="checkbox"/> Decubiti <input type="checkbox"/> Bedridden <input type="checkbox"/> Eczema-severe <input type="checkbox"/> Normal	<input type="checkbox"/> Dialysis in home <input type="checkbox"/> Ostomy <input type="checkbox"/> Incontinent – Age > 3 years <input type="checkbox"/> Catheterization <input type="checkbox"/> Continent	<input type="checkbox"/> Level I (5 or > surgeries) <input type="checkbox"/> Level II (< 5 surgeries) <input type="checkbox"/> None	Day care Services <input type="checkbox"/> High Tech - 4 or more times per week <input type="checkbox"/> Low Tech – 3 or less times per week or MD visits > 4 per month <input type="checkbox"/> None
38. Neurological Status			
<input type="checkbox"/> Deaf <input type="checkbox"/> Blind <input type="checkbox"/> Seizures <input type="checkbox"/> Neurological Deficits <input type="checkbox"/> Paralysis <input type="checkbox"/> Normal			
39. Other Therapy Visits <input type="checkbox"/> Five days per week <input type="checkbox"/> 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: _____	
<b>DO NOT WRITE BELOW THIS LINE</b>			
44. Continued Stay Review Date: _____ Admission Date _____ Approved for _____ Days or _____ Months			
45. Are nursing services, rehabilitative services or other health related services requested ordinarily provided in an institution? <input type="checkbox"/> Yes <input type="checkbox"/> No		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 <input type="checkbox"/> Met <input type="checkbox"/> Not Met			
48. Level of Care Recommended by Contractor <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility <input type="checkbox"/> IC/MR Facility			
49. Approval Period	50. Signature (Contractor) _____	51. Date /   /	52. Attachments (Contractor) <input type="checkbox"/> Yes <input type="checkbox"/> No