

PEDIATRIC DMA 6(A)

**PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE**

<b>Section A – Identifying Information</b>					
1. Applicant's Name/Address: Name: _____ Address: _____ DFCS County: _____		2. Medicaid Number: _____		3. Social Security Number _____	
				4. Sex _____ Age _____ 4A. Birthdate _____	
		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 Georgia Department of Community Health and the Department of Human Services, 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: _____ <i>(Parent or other Legal Representative)</i>			11. Date: ____/____/____		
<b>Section B – Physician's Report and Recommendation</b>					
12. History: <i>(attach additional sheet if needed)</i>					
13. Diagnosis 1) _____ 2) _____ 3) _____ <i>(Add attachment for additional diagnoses)</i>				1. ICD	2. ICD
				3. ICD	
14. Medications			15. Diagnostic and Treatment Procedures		
Name	Dosage	Route	Frequency	Type	Frequency
16. Treatment Plan <b>(Attach copy of order sheet if more convenient or other pertinent documents)</b>					
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  _____ <b>Physician's Signature</b>					
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)**

<b>29. Nutrition</b> <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 <input type="checkbox"/> Meds	<b>30. Bowel</b> <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 _____	<b>31. Cardiopulmonary Status</b> <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	<b>32. Mobility</b> <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	<b>33. Behavioral Status</b> <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
<b>34. Integument System</b> <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	<b>35. Urogenital</b> <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	<b>36. Surgery</b> <input type="checkbox"/> Level 1 (5 or > surgeries) <input type="checkbox"/> Level II (< 5 surgeries) <input type="checkbox"/> None	<b>37. Therapy/Visits</b> 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	<b>38. Neurological Status</b> <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
<b>39. Other Therapy Visits</b> <input type="checkbox"/> Five days per week <input type="checkbox"/> Less than 5 days per week		<b>40. Remarks</b>		
<b>41. Pre-Admission Certification Number:</b> _____			<b>42. Date Signed</b> ____/____/____	
<b>43. Print Name of MD or RN:</b> _____  <b>Signature of MD or RN:</b> _____				
<b>DO NOT WRITE BELOW THIS LINE</b>				
<b>44. Continued Stay Review Date:</b> _____ <b>Admission Date:</b> _____ <b>Approved for</b> _____ <b>Days or</b> _____ <b>Months</b>				
<b>45. Are nursing services, rehabilitative services or other health related services requested ordinarily provided in an institution?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>46A. State Authority MH &amp; MR Screening</b> Level I/II Restricted Auth. Code                      Date		
		<b>46B. This is not a re-admission for OBRA purposes</b> Restricted Auth. Code                      Date		
<b>47. Hospitalization Precertification</b> <input type="checkbox"/> Met <input type="checkbox"/> Not Met				
<b>48. Level of Care Recommended by Contractor</b> <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility <input type="checkbox"/> IC/MR Facility				
<b>49. Approval Period</b>	<b>50. Signature (Contractor)</b> _____	<b>51. Date</b> ____/____/____	<b>52. Attachments (Contractor)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

**PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE**

**INSTRUCTIONS FOR COMPLETING THE PEDIATRIC CARE FORM DMA-6(A)**

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 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, hospital or institution for the mentally retarded. 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.

**Read the statement below the name(s) of the caregiver(s) and then;**

**Item 10: Signature**

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 code. 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 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; hospital, nursing facility, or intermediate care facility for the mentally retarded. 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 or could not be managed by provision of the Community Care or Home Health Care Services Programs. Check in the box corresponding to "could" and either/both the box(es) corresponding to Community Care and/or Home Health Services if either/or both is appropriate. Check the box corresponding to "could not" if neither 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 nursing facility, hospital, or an intermediate care facility for the mentally retarded.

**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 Georgia license number.

**Item 28: Physician's Telephone Number**

Enter the attending or admitting physician's telephone number including area code.

**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.**

**Do Not Write Below This Line**

Items 44 through 52 are completed by Contractor staff only.