

**INSTRUCTIONS**  
**DHS 1147e**  
**(07/06)**

**CHILDREN/YOUTH**  
**EPSDT SERVICES REQUEST AND AUTHORIZATION**  
**LEVEL OF CARE (LOC)/SERVICES DETERMINATION**

**Top of Form: Initial Request, 6-Month Review, Annual Review, Other Review:** Check the most appropriate box for the level of care (LOC)/service request. Note: Check only one box per request.

For all initial requests, check the “Initial Request” box. Once a level of care is determined and/or services are authorized, new forms shall be submitted based on the appropriate review period. Services will be authorized consistent with the review period. At a minimum, each medically fragile client will be reviewed and services authorized every 6 months. For these clients, check the “6-month review” box. Check the “annual review” box for other clients who are in nursing homes, in the community at ICF level of care or in Medicaid waiver programs such as Nursing Home Without Walls (NHWW), or HIV Community Care (HCC). If the review is being requested either by the Department of Human Services or its agent, or if the review is being requested due to medical and/or level of care changes, select “Other Review.”

1. **Name:** Self-explanatory
2. **Medicaid I.D. Number:** Enter Medicaid I.D. number of the patient assigned by the Department of Human Services. If the I.D. number is unknown, use one of the verification systems to find the I.D. number of the patient. If the patient has applied for Medicaid but has not yet been deemed eligible, write in “pending” and the application date.
3. **Birthdate:** Self-explanatory
4. **Sex:** Self-explanatory
5. **Other Insurance:** Identify whether the patient has other insurance. If so, check “yes” and identify insurer and policy number if available. If patient has no other insurance, check “no.” Do not leave blank. Check one box.
6. **Present Address/Facility:** Identify facility name if patient is residing in a facility. If patient is at another location, enter street address, city and zip code. Check the appropriate box that identifies the patient’s residence. Do not leave blank. Check one box.
7. **Provider I.D. Number:** Enter the Medicaid I.D. number of the provider (hospital, nursing home or physician) responsible for the child’s care.
8. **Attending Physician:** Self-explanatory.

9. **Provider I.D. Number:** Enter the Medicaid I.D. number of the attending physician. It may be the same as the provider number in box 7 if the patient is residing in the community and NOT in a facility.
10. **Contact Person:** Enter the name, title and phone number of the person able to provide additional information about the patient. In most cases, it will be the case manager for the patient. In other cases, it may be the primary contact in the hospital or nursing home.
11. **Return Form:** Indicate how the form should be returned (i.e., fax or mail) and to whose attention (name of hospital, nursing home, or case management agency). The form will NOT be mailed with a cover sheet so the information must be accurate. The contact information in box 10 will be used to identify the specific individual within the case management agency, hospital or nursing home that will be receiving the completed form.
12. **Referral Information:** Complete all sections.
  - A. **Source(s) of Information:** Identify the information available on the patient.
  - B. **Parent/Guardian:** Provide the name, relationship, phone and fax numbers of the parent/guardian who will be making decisions for the patient.
  - C. **Language:** Check the box of the primary language spoken by this individual. If checking "Other," indicate the language spoken. Information is used to obtain interpreters.
13. **Assessment Information:** Complete all sections.
  - A. **Assessment Date:** Date the most current assessment was completed.
  - B. **Assessor's Name, Title, Signature, Phone and Fax Numbers:** A registered nurse (RN) or physician must perform the assessment. Enter the name, title, and telephone and fax numbers of the assessor. Have assessor sign the form.
14. **Requesting:** Check all of the services that are being requested. Referrals to the Medicaid Home and Community-Based Services (HCBS) can be made at the same time as submittal of this form. If requesting EPSDT Case Management or EPSDT skilled nursing hours, the requester may identify the code, provider, skilled nursing hours being requested, and the period of time (to and from dates). This does not guarantee that the requested service will be authorized.

If HCBS is being offered, indicate whether counseling was provided and by whom. Provide an explanation if the person did not receive information and/or counseling.

If EPSDT case management is being requested for the first time, the service plan must be submitted once it is completed. If EPSDT case management is being requested to be continued, the service plan must be attached to the form.

15. **Medical Necessity/Level of Care Action:** To be completed by DHS or Designee. Leave Blank. DO NOT COMPLETE. A copy of the completed form will be sent (via mail or fax as identified in box 11).
16. **Service Authorization:** The requester may complete the provider name and provider number for EPSDT case management, skilled nursing and personal care. Be sure to enter the correct provider number(s) for the services. DO NOT COMPLETE the rest of this area. It will be completed by DHS or Designee. A copy of the completed form will be sent (via mail or fax as identified in box 11).

## PAGE 2 AND 3– APPLICANT/CLIENT BACKGROUND INFORMATION

1. **Name:** Self-explanatory
2. **Birthdate:** Self-explanatory
3. **Functional Status Related to Health Conditions:** Complete all sections.
  - A. **List significant current diagnosis(es):** List the main diagnosis(es) or medical conditions related to the person’s need for long-term care or community-based services.
  - B. **Medications/Treatments:** List the significant medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term (such as antibiotics), or significant PRN medications (such as narcotics and sedatives). Do not list stool softeners, enemas, and other agents to treat constipation, acetaminophen, non-steroidal anti-inflammatory agents (NSAIDs) unless they are given at least daily. If a patient has more than five (5) significant medications, attach orders or treatment sheet. As an option to completing this section, the most current prescription listing can be attached. If using this option, please indicate “attached” in this area.
  - C. **Activities of Daily Living:** Check all of the areas that the individual requires assistance on a regular basis, considering developmental age. If the client is a newborn, he/she is not expected to toilet, feed, transfer and dress him/herself. Therefore, these areas would NOT be checked. However, in the case of a 3-year old, the developmentally appropriate child would be expected to walk, toilet and feed himself. If the child requires assistance in those areas, the appropriate boxes should be checked. Use space on page 3, section 7 to identify how much assistance (minimal or total) is required.
  - D. **Non-Vent, Non-Trach Case Management:** Indicate whether an individual who is not vent or trach dependent can benefit from case management. Provide an explanation on page 3.
  - E. **Care Plan Change:** Indicate whether a new care plan has been developed for the patient. If so, attach the most current care plan. This assumes the most recent previous care plan has been provided to the Department.

4. **Nursing Interventions:** Check the nursing intervention(s) that apply. Hospital admissions for minor procedures such as elective admissions, assessments, or adjustments are not provided any nursing points. Only readmissions for exacerbation of existing medical condition or new diagnosis should be noted on the form. Total the number of points based on the nursing interventions. Comatose patients (meeting Levels I or II of the Rancho Los Amigos Scale) are assigned 30 points.
5. **Other Considerations:** Check all circumstances that apply to the child's family. Total the number of points for family circumstances and add to the nursing interventions to get total points.
6. **School Attendance Information:** Complete the information on the child's attendance at school. Put N/A if child is not attending school or is too young to attend school. If attending school, identify the type of school attending. Private and public schools refer to schools managed by private entities or the Department of Education. Home schooled refers to the parents' choice to school the child at home without DOE or private teachers. Home/hospital refers to schooling provided by the DOE either in the home or hospital environment.
7. **Comments and Explanations for Medical Condition, Functional Status or Skilled Nursing:** Provide any additional information, comments or explanation of the child's functional assessment, nursing intervention requirements.
8. **Comments on Family/Social Situation:** Provide any additional information, comments or explanations of the child's family social situation that will impact the health of the child.

**Physician's Signature:** Self-explanatory.

**Date:** Date that physician signs the form.

**Physician's Name:** Self-explanatory.