TEFRA MEDICAID
NURSING FACILITY LEVEL-OF-CARE
(Page 1)

Division of Public Assistance
3601 C Street, Ste 460
PO Box 240249
Anchorage, AK 99524-0249

SECTION ONE: Identifying Information (To be completed by Care Coordinator)

Care Coordinator Name:	Agency Name and Mailing Address:	Phone Number(s):	Email:
☐ Initial (New)	☐ Reassessment	Date of Assessment: (Date child seen/evaluated by care coordinator)	
Name of Child: (Last, First)		Date of Birth:	Sex: ☐ Male ☐ Female
Parent(s) Name:	Address: (Physical and Mailing)		Phone Number(s):

SECTION TWO: Physician's Evaluation (To be completed by child's physician)

Physician Name: (Please Print)	Physician Address and Phone:	Date of last office visit:	Number of office visits or MD contacts (phone, email, etc) in last twelve months:
Primary Diagnosis:		Secondary Diagnosis:	
Medications: (include dosage and frequency)		Is child referred to any specialists? If yes, list name and specialty:	
Physician Signature:		Date:	

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Note: This page is to be completed and signed by the Care Coordinator. Instructions: Complete Section Three for initial requests only, Complete both Sections Three and Four for all renewals.

SECTION THREE: Plan of Care (To be completed for both initial requests and yearly renewal requests.)

Note: If more room is needed please use separate piece of paper and attach to form.

List current nursing needs: (Nursing needs are defined as any services the child needs that can only be provided by licensed nursing personnel i.e. ventilator support, feeding tubes, speech therapy, etc.)

Rehabilitation goals: ☐ Maintenance or ☐ Active (Note if Active, list goals, progress and projected time frames)

Discharge Plan: ☐ Yes ☐ No (Note: If Yes, State Plan with Time Frame. If No, indicate why not)

SECTION FOUR: Annual Review of Medical Needs (To be completed for yearly renewals only.)

Major medical problems since last review: (List dates, duration, and treatment(s))

Number of hospitalizations since last review: (List hospital, date(s) of hospitalization, and reason)

Since last review have there been any unusual occurrences in child's life? ☐ Yes ☐ No, If yes, please explain and list dates of occurrence

SECTION FIVE: Medical Documentation	***Relevant*** medical and/or development documentation from the past year is attached to the form ☐ Yes ☐ No If NO, please explain why: **(Note, Qualis Health cannot make a determination without medical documentation supporting the claims on this form.)**

Care Coordinator Signature: (Note: By signing this form you are stating that all claims on this form or true and accurate.)	Date:

Please submit completed form with attached medical and/or developmental documentation to: Qualis Health (Attn: TEFRA Nurse) 721 Sesasme St. 1A Anchorage, AK 99503	Questions: Contact TEFRA Nurse at (907) 562-2755 (In Anchorage) 1-888-578-2547 (Outside Anchorage)