PHYSICIAN EVALUATION FOR KATIE BECKETT COVERAGE GROUP

INSTRUCTIONS TO THE FAMILY

Dear Parent:

This physician report is required for initial approval or clinical re-determination for the Katie Beckett Program. Please complete the first section and give or mail this form to the doctor who is treating the condition or disability that you believe may allow your child to be eligible for Katie Beckett coverage. If you have any questions, please call our office at 401-462-0070.

Child's Name Last First MI		Date of Birth
Social Security Number _____ _____ _____	Sex: M F	Home phone:
Parent to Contact:	Contact number (s)	
Mailing Address:		
City or Town:	State	Zip Code

INSTRUCTIONS TO THE PHYSICIAN

Dear Doctor:

This form contains an outline of clinical information required to determine the above child's eligibility for the Katie Beckett Coverage Group. To qualify, children (under age 19 years) must meet SSI disability criteria, live at home, *and* require services ordinarily provided in a hospital (medical or psychiatric), skilled nursing facility, or intermediate care facility for mental retardation (ICF/MR). Additional details regarding these criteria can be found at www.ssa.gov and www.dhs.ri.gov. You are also welcome to call me at (401) 462-0070.

You are encouraged to submit copies of medical records that contain the information requested. In general, such records contain information about the components of your evaluation, treatment plan, progress and prognosis. . Dictations from recent comprehensive evaluations, discharge summaries, and other extended reports are ideal. There is no need for you to duplicate your prior work product.

This form requires the signature of a physician, either a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) After signing where indicated please fax the completed form to (401) 462-6353 or mail to address below:

Sincerely,

Michelle Bouchard, RN

Michelle Bouchard, RN
Public Health Nurse Consultant

The Katie Beckett Unit
RI Executive Office of Health and Human Services
Center for Child and Family Health
Hazard Building (Building 074)
74 West Road, Ground Level
Cranston, RI 02920

I. Primary diagnoses requiring daily specialized care and support beyond those of a typically developing child:	II. Supporting clinical findings (History and Physical, laboratory findings, specialist evaluations) for each diagnosis listed at left:	III. Original Medical Records Appended:
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.

Other diagnoses, surgeries, and treatments (If the child was hospitalized within the past three years, please attach the discharge summary or include dates of admission and diagnoses).

Hospital Name:	Admitting Diagnosis:	Date(s) Admitted:

Surgeries (procedures and dates): _____

Other Treatments and Date Performed: _____

Medications with dosages:

_____

_____

_____

Please describe any assistance that the child requires to perform activities of daily living, which substantially exceeds that required for typically developing children of the same age:

_____

_____

_____

Specialized and /or skilled services required for Cognition, Speech and Language, Psychosocial Development, Mobility and/or self-help skills eg., CEDARR, HBTS, PASS, skilled nursing services.

_____

_____

_____

_____

Physician's printed name Physician's signature Date

COPIES OF MEDICAL RECORDS COVERING THE CHILD'S DIAGNOSIS AND CONDITION MAY BE SUBMITTED IN CONJUNCTION WITH THIS FORM.