



PARTNERS FOR CHILDREN (PFC) Medical Eligibility and Level of Care Determination Form

Date:	Initial Determination <input type="checkbox"/>	Redetermination: Annual <input type="checkbox"/> Interim <input type="checkbox"/>
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Participant Information

Participant Name:		
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Language:
CCS Number:	Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medi-Cal Number:	Ethnicity/Culture:	
Other ID:	Date of Enrollment:	
Notes:		

Parent/Legal Guardian

Name (1):	Relationship:
Name (2):	Relationship:
Name (3):	Relationship:
Notes:	

Referral Information (initial only) Date:

Referring Person:	Title/Relationship:	
Referring Person Phone:	Phone:	Email:
Address:		
Department/Unit	Hospital/Office	
Street Address	Suite/Mail Stop	
City	State	Zip
Special Care Center (SCC):		
Primary or SCC Physician:	Phone:	
Initial Medical Report(s) Received and Reviewed: <input type="checkbox"/> Y <input type="checkbox"/> N		
Reports Received:		
Notes:		

Reason(s) for Referral

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Medical Eligibility

Check all applicable CCS Medically Eligible Waiver Conditions

<input type="checkbox"/>	<p>Neoplasms</p> <ul style="list-style-type: none"> <input type="checkbox"/> Neoplasm, Stage 3 or 4 <input type="checkbox"/> Any neoplasm not responding to conventional protocol (at least one relapse) <input type="checkbox"/> Central nervous system tumors
<input type="checkbox"/>	<p>Cardiac</p> <ul style="list-style-type: none"> <input type="checkbox"/> Major cardiac malformations <input type="checkbox"/> Severe anomalies of Aorta and/or Pulmonary Arteries <input type="checkbox"/> Heart Failure
<input type="checkbox"/>	<p>Pulmonary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cystic Fibrosis with multiple <input type="checkbox"/> Pulmonary hypertension <input type="checkbox"/> Refractory pulmonary hypertension <input type="checkbox"/> Pulmonary hemorrhage <input type="checkbox"/> Chronic or severe respiratory failure
<input type="checkbox"/>	<p>Immune</p> <ul style="list-style-type: none"> <input type="checkbox"/> AIDS <input type="checkbox"/> Severe Combined Immunodeficiency Disorder <input type="checkbox"/> Other severe immunodeficiencies
<input type="checkbox"/>	<p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chronic intestinal failure dependent on TPN <input type="checkbox"/> Other severe gastrointestinal malformations <input type="checkbox"/> Liver failure
<input type="checkbox"/>	<p>Renal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Renal failure
<input type="checkbox"/>	<p>Neurologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Holoprosencephaly or other severe brain malformations requiring ventilatory or alimentary support <input type="checkbox"/> CNS injury with severe comorbidities <input type="checkbox"/> Severe cerebral palsy/HIE <input type="checkbox"/> Batten Disease <input type="checkbox"/> Severe neurologic sequelae of infectious disease or trauma
<input type="checkbox"/>	<p>Metabolic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Severe and progressive metabolic disorders including but not limited to: leukodystrophy, Tay-Sachs disease, and others with severe comorbidities <input type="checkbox"/> Mucopolysaccharidoses that meets Level of Care criteria below
<input type="checkbox"/>	<p>Neuromuscular</p> <ul style="list-style-type: none"> <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Spinal muscular atrophy, Type I or II <input type="checkbox"/> Other myopathy or neuropathy with severity that meets Level of Care criteria below
<input type="checkbox"/>	<p>Other conditions that meet Level of Care criteria below, including but not limited to:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Severe epidermolysis bullosa <input type="checkbox"/> Severe osteogenesis imperfect <input type="checkbox"/> Congenital infection with severe sequelae (e.g. CMV, HSV, toxoplasmosis) <input type="checkbox"/> Post-organ transplant with complications <input type="checkbox"/> Other conditions will be given ICD-10 code on a case by case basis. Enter Code:

Notes:

Level of Care Criteria

In the absence of waiver services the participant is expected to require acute hospital services for at least 30 days during the year.
Yes **No**

For annual and interim redeterminations: Additional medical records received and reviewed. **Yes** **No**

Briefly summarize the participant’s medical condition(s), including care and treatment(s) which meet the medical eligibility criteria and level of care for waiver participation. Include the identified CCS medically eligible waiver condition(s), review of the submitted medical records, and information available in CMSNet.

Notes:

Waiver Eligible

- Meets** Medical Eligibility for Waiver Participation
- Meets** Level of Care Criteria for Waiver Participation
- Contact with applicant/family indicates interest in enrolling (or placement on waiting list if necessary)
- Initial:** Proceed to enrollment Date of Enrollment:
- Annual/Interim:** Approved to continue waiver participation Date of Approval:
- Placed on county waiting list (no available providers) Date: Position on list:
- Contacted State for placement on state waiting list (no available slots) Date: Position on list:

Notes:

Not Waiver Eligible

- Does Not Meet** Medical Eligibility Criteria
- Does Not Meet** Level of Care

Reason(s):

- Referral Discussed With: CCS County Medical Consultant State CMS Waiver Contact
- Initial:** Do not enroll **Annual/Interim:** Not approved to continue waiver participation Date Disenrolled:
 - Notice of Action Sent Date:
 - Other Action Taken:

Notes:

CCS Nurse Liaison

Name: _____

CCS Office: _____

Phone: _____ FAX: _____

Email: _____

Civil Code Section 1798.17 provides that the individual will be notified of the intended purpose and use of personal information being collected. Information on this document will be used exclusively by the Department of Health Care Services and affiliates of the Partners for Children program for the purposes of monitoring and providing quality services to PFC participants.