Rhode Island Department of Human Services

CLINICAL EVALUATION FOR KATIE BECKETT COVERAGE GROUP

INSTRUCTIONS TO THE FAMILY

Dear Parent:

This provider report is required for initial approval or clinical redetermination for the Katie Beckett Program. Please complete the first section and give this form to the provider who is treating your child's condition or disability.

Child's Last Name	First Name	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 PROVIDER

Dear Provider:

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. Additional details regarding these criteria can be found at www.ssa.gov and www.eohhs.ri.gov. You may also call DHS to speak with our parent consultant at (401) 574-8474 or email: DHS.PedClinicals@dhs.ri.gov

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 an MD, DO, APRN, Audiologist, Psychiatrist or Psychologist. Please email to: DHS.PedClinicals@dhs.ri.gov or Fax: to the address below: 401-574-9915 or mail to:

Long Term Services and Supports | Katie Beckett
Department of Human Services
P.O Box 8709
Cranston, RI 02920

Page 2: Child's Name _____

I. Primary diagnoses requiring daily specialized care and support beyond those of a typically developing child:

1. _____

2. _____

3. _____

4. _____

II. Supporting clinical findings (history and physical, laboratory findings, specialist evaluations) for each diagnosis listed at left:

1. _____

2. _____

3. _____

4. _____

Hospital Name:

Admitting Diagnosis:

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, e.g., CEDARR, HBTS, PASS, skilled nursing services.

Provider's printed name | Provider's signature & Title | Date

COPIES OF MEDICAL RECORDS COVERING THE CHILD'S DIAGNOSIS AND CONDITION SHOULD BE SUBMITTED ALONG WITH THIS FORM.