LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Revised 6/20/2024

ACT 421 – CHILDREN'S MEDICAID OPTION (TEFRA)

HEALTH RECORD REQUEST FORM

Name of Child: _____

Name of Parent/Legal Guardian: _____

Contact Phone Number: _____

Supporting documentation (e.g., IEP, pupil appraisal, medical records, psychological testing, etc.) and provider information for **ALL** reported diagnoses/treatments **MUST** be provided in order to complete an accurate level of care assessment. Failure to provide this information may result in a Level of Care denial for Act 421 Children's Medicaid Option.

Please reach out to your Local Governing Entity (LGE) with any questions you have about this form. If you need more space use question 11 or attach additional pages.

DIAGNOSIS INFORMATION

1. What are the child's current diagnoses?

Diagnosis	Name/Title of Person Who Made the Diagnosis	Date of Diagnosis *(mm/dd/yyyy)*

2. Communication and Understanding – Has the child participated in any speech/language testing? ☐ Yes ☐ No
If yes, provide the following information:

Test Name		
Date of Test *(mm/dd/yyyy)*		
Expressive Language Score *(if not known or available, leave blank)*		
Receptive Language Score *(if not known or available, leave blank)*		
Name of Person Giving Test		
Address of Person Giving Test		

3. Learning and Comprehension – Has the child participated in any intelligence testing? ☐ Yes ☐ No
If yes, provide the following information:

Test Name		
Date of Test *(mm/dd/yyyy)*		
Full Scale IQ		
Name of Person Giving Test		
Address of Person Giving Test		

4. Providers – List all current providers (physicians, home health, social service, etc.) and their contact information:

Name of Provider	Address	Phone Number	Specialization

5. Therapy – Has the child participated in any therapies in the last two years (occupational, physical, speech, etc.)?
☐ Yes ☐ No
If yes, please provide the following information:

Name of Provider			
Address			
Phone Number			
Type of Therapy			
Place of Therapy *(school, home, clinic, etc.)*			
Number of Sessions *(per week)*			

6. Hospitalizations – Has the child been in the hospital in the past two years? ☐ Yes ☐ No
If yes, please provide the following information:

Name of Hospital			
Address of Hospital			
Reason for Admission			
Date of Admission *(mm/dd/yyyy)*			
Date of Discharge *(mm/dd/yyyy)*			

7. Current Medications – Does the child routinely take any prescription medications (including chemotherapy)? ☐ Yes ☐ No
If yes, please provide the following information:

Name of Medication	How Often	How Taken	Side Effects

8. Current Medical/Nursing Care Needs – Does the child have any current care needs? ☐ Yes ☐ No
If yes, please provide the following information:

Care Needed		How Often	Start Date *(mm/dd/yyyy)*	Amount of Help Needed
☐	Apnea monitor			
☐	Nebulizer			
☐	Oxygen			
☐	Suction			
☐	Tracheostomy care			
☐	Ventilator			
☐	IV line indwelling			
☐	Total Parenteral Nutrition (TPN)			
☐	Bowel program			
☐	Dialysis			
☐	Ostomy care			
☐	Tube feeding			
☐	Urinary catheter care			
☐	Other:			
☐	Other:			
☐	Other:			
☐	Other:			

9. School – Does the child have an Individualized Education Program (IEP)? ☐ Yes ☐ No
   Is the child enrolled in special education? ☐ Yes ☐ No
   If yes to either of these questions, please provide the following information:

Name of School			
Grade Level			
Name of Teacher			
Address			
Phone Number			

10. If you have any of the following for your child, please indicate below and attach to this application:

	Assessment/Document	**Date of Completion** *(mm/dd/yyyy)*	**Name/Title of Person Who Completed Document**
☐	Individualized Education Plan (IEP)		
☐	Inventory for Client and Agency Planning		
☐	Individualized Family Services Plan (IFSP) with the Battelle Development Inventory (BDI)		
☐	Ages & Stages Questionnaire		

11. If you have any additional information, please include it below:

Form completed by:

Signature _____ Print Name _____ Date *(dd/mm/yyyy)* _____