

TEFRA INPATIENT PSYCHIATRIC HOSPITAL
LEVEL OF CARE (LOC) DETERMINATION
(ref: 7 AAC 100.002 and 7 AAC 100.4249 (c))

Applicant Name:

Date of Birth:

The applicant **must meet all six** of the following criteria. **Supporting documentation must be provided for each criterion.** If supporting documentation is not attached the LOC decision will be delayed.

<p><u>Criterion 1:</u> Applicant must have a mental illness or severe emotional disturbance diagnosed by a psychiatrist or mental health professional clinician. The condition has persisted six months and is expected to persist for total of 12 months or longer.</p> <p>If yes complete the following:</p> <p>DSM IV diagnosis: _____ Date of diagnosis: _____</p> <p>Diagnosis made by: _____ Title & Agency: _____</p>		
<p><u>Criterion 2:</u> Applicant must have <u>at least one</u> of the following mental health symptoms:</p> <p><input type="checkbox"/> Psychotic symptoms, characterized by defective or lost contact with reality, hallucinations or delusions</p> <p><input type="checkbox"/> Suicidal behavior, in the 90 day period before the date of application, as demonstrated by the individual having made a suicidal attempt</p> <p><input type="checkbox"/> Significant suicidal thoughts, in the 30 day period before the date of application, that include a plan for suicide</p> <p><input type="checkbox"/> Violent behavior, the 30 day period before the date of application, as characterized by a documented attempt by the individual to cause injury to a person or substantial property damage as the result of an emotional disturbance</p>		
<p><u>Criterion 3:</u> Applicant must have functional impairments, relative to expected development levels for that age and at a level that qualified the child to receive inpatient psychiatric hospitalization, in <u>at least three (3)</u> of the following areas:</p> <p><input type="checkbox"/> Self-care <input type="checkbox"/> Interaction with the community</p> <p><input type="checkbox"/> Social relationships <input type="checkbox"/> Family relationships</p> <p><input type="checkbox"/> Functioning at school or work</p>		
<p><u>Criterion 4:</u> Absent appropriate intervention in the home and community, applicant must require psychiatric hospitalization as <u>documented by a mental health professional.</u></p>		
<p><u>Criterion 5:</u> Applicant <u>must require</u> a level of care in the home that is typically provided in a psychiatric hospital because the child is suffering from a mental illness or emotional disturbance that is likely to result in serious harm to self others.</p>		
<p><u>Criterion 6:</u> Applicant must be expected to functionally improve or can avoid further deterioration if care is provided in the home and community.</p>		
Care Coordinator Name:	Signature of Care Coordinator:	Date:
Name of QUALIS Nurse Reviewer:	Signature of Nurse Reviewer:	Date: