Partnership HealthPlan of California
Outpatient Pediatric Palliative Care
Eligibility Assessment Form

Member Name:_____ CIN: _____

County of Residence: _____ Contact Phone Number: _____

DOB: _____ Today's Date:_____ Current Age: _____

Name of Palliative Care Provider Organization: _____

General criteria: Check each of the following that apply (All needed for eligibility)

- ☐ **Has Partnership HealthPlan of California as their primary insurance**
- ☐ **Parent(s) or legal guardian and the child (if cognitively able) agree to accept Outpatient Pediatric Palliative Care Services**
- ☐ **Is 20 years of age or younger**
- ☐ **Has an eligible medical condition**
- ☐ **Parent or legal guardian declines hospice enrollment or the member is not eligible for hospice enrollment**
- ☐ **Meets the Level of Care criteria**

Diagnosis:_____ ICD10 Code: _____

Date of Diagnosis _____

Date(s) of most recent hospitalizations (in the last 6 months) _____

_____

Highlights of Treatment Course to Date:

Estimate of anticipated unplanned inpatient days in the next calendar year if palliative care is not provided:_____

Which one or more of the following apply:

- ☐ Curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease)
- ☐ Intensive long-term treatment aimed at maintaining quality of life is required (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy)
- ☐ Progressive condition for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta)
- ☐ Severe, non-progressive disability
- ☐ Extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

Supporting Details: