Division of Health Care Financing and Policy
Long Term Services and Supports
Katie Beckett Eligibility Option
Comprehensive Statement of Understanding

Medicaid Recipient:_____

Medicaid ID: _____ Date of Birth: _____

Parent/Legal Guardian Responsibilities:

I understand I have the responsibility to:

- Notify the Division of Health Care Financing and Policy (DHCFP) Health Care Coordinator (HCC) and the Division of Welfare and Supportive Services (DWSS) Family Service Specialist (FSS) of a change in my child's Medicaid eligibility.
- Notify the DHCFP HCC and the DWSS FSS of my child's current insurance information, including the name of other insurance coverage.
- Notify the DHCFP HCC of changes in my child's medical status, including admission to a hospital, nursing home or residential treatment center.
- Notify the DHCFP HCC and the DWSS FSS of demographic information changes for my child such as address, telephone numbers, etc.
- Obtain all medical/therapy/psychological/school records for my child as requested by the DHCFP HCC.
- Obtain a physician signature on a Physician Statement form as requested by the DHCFP HCC.
- Promptly respond to the DHCFP HCC's request for an annual home visit appointment.
- Review the Quarterly Allowable Costs for changes at: www.dhcfp.nv.gov.
  Select: Programs, Long Term Services & Support, Katie Beckett Eligibility Option, Resources, Katie Beckett Allowable Costs.
- I understand that if I am unable to access the Quarterly Allowable Costs via the Internet, I may request this information from the DHCFP Medicaid District Office on a quarterly basis.
- Sign all required forms.

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I further understand that:

Failure to abide by the above requirements may result in a denial or termination of my child's eligibility for the Katie Beckett Eligibility Option.

I have read the Statement of Understanding and understand the contents of this form ☐.

Parent/Legal Guardian Signature Date

Relationship to Medicaid Recipient Date

DHCFP HCC Signature Date