08OA001E-001

CASE ID _____

OKLAHOMA
Health Care Authority

Tax Equity and Financial Responsibility Act (TEFRA) Home Care Program

Physician Assessment for TEFRA

1. Child information

Last name	First name	MI	Gender ☐ M ☐ F	
Date of birth	Social Security number	Race	Area code	Phone
Current residence: Home ☐ Hospital ☐ Other ☐ Specify:				
Street address	City	County	State	Zip
Insurance company and policy number				
Facility/hospital where child last received care				
Street address	City	State	Zip	

2. Parent/Guardian/Authorized Representative Contact Information

Last name	First name	MI	Gender ☐ M ☐ F	
Street address	City	County	State	Zip
Area code	Phone	Relationship to child		
Last name	First name	MI	Gender ☐ M ☐ F	
Street address	City	County	State	Zip
Area code	Phone	Relationship to child		

3. Personal History

Primary caregiver name	Relationship to child
Does primary caregiver work? ☐ Yes ☐ No	Caregiver's work schedule, days, hours: Mon ____ Tue _____ Wed _____Thurs _____Fri ____ Sat____ Sun_____
Secondary caregiver name	Relationship to child
Does secondary caregiver work? ☐ Yes ☐ No	Caregiver's work schedule, days, hours: Mon ____ Tue _____ Wed _____Thurs _____ Fri _____Sat ____Sun____

School Services Education

Is child in school?	School schedule, days, hours:
☐ Yes ☐ No	Mon _____ Tue _____ Wed _____ Thurs _____ Fri _____

Indicate if the child has:

☐ Individual Education Plan (IEP)

☐ Individual Health Service Plan (IHSP)

☐ Individual Family Service Plan (IFSP)

School Services / Therapies

Type of service/therapy	Days, hours: Mon _____ Tue _____ Wed _____ Thurs _____ Fri _____
Type of service/therapy	Days, hours: Mon _____ Tue _____ Wed _____ Thurs _____ Fri _____

4. Medications

Attach additional sheet if needed. List all medications including injections and intravenous medications.

Name	Dose	Route	Frequency	Monthly cost

5. Home Care Needs

Respiratory Care

☐ Pulse oximetry ☐ CPT ☐ Trach care/suctioning frequency _____ **Monthly cost $_____**

Is child on oxygen? ☐ Yes ☐ No Hours/day on oxygen _____ **Monthly cost $_____**

Is child on ventilator? ☐ Yes ☐ No Hours/day on ventilator _____ **Monthly cost $_____**

Is child on CPAP ☐ Yes ☐ No Day ☐ Night ☐ **Monthly cost $_____**

Is child on BiPAP ☐ Yes ☐ No Day ☐ Night ☐ **Monthly cost $_____**

Catheter Care

Describe care provided	**Monthly cost $**

Ostomy Care

Describe care provided	**Monthly cost $**

Nutritional Care

Check all that apply: Oral/G-tube/J-tube ☐ Enteral ☐ Parenteral ☐	**Monthly cost $**
Nutritional supplements Frequency used	**Monthly cost $**

Equipment Rental

Describe equipment rented	**Monthly cost** **$**

6. Home Services Provided

Nursing care provider	Area code	Phone
Describe nursing care provided		
Monthly cost **$**	Days, hours: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____	
Physical therapy provider	Area code	Phone
Describe physical therapy provided		
Monthly cost **$**	Days, hours: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____	
Occupational therapy provider	Area code	Phone
Describe occupational therapy provided		
Monthly cost **$**	Days, hours: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____	
Speech therapy provider	Area code	Phone
Describe speech therapy provided		
Monthly cost **$**	Days, hours: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____	
Other therapy provider	Area code	Phone
Describe other therapy provided		
Monthly cost **$**	Days, hours: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____	

I certify that the information I have completed is true and correct to the best of my knowledge and understand that providing any false information may result in prosecution for perjury or fraud.

Parent/Guardian signature _____ Date _____

TEFRA email: TEFRAFAX@okhca.org **TEFRA fax: 405-530-3312**

Oklahoma Health Care Authority 4345 N. Lincoln Blvd. Oklahoma City, Ok. 73105

Child's Last name _____ First name _____ DOB _____ Gender ☐ M ☐ F

Physician recommendation: *To be completed by an MD or DO.*

TEFRA coverage allows children with physical and/or intellectual disabilities, who are not eligible for SSI benefits because the family income and resources are too high, to qualify to receive medical benefits. The benefits help pay for the medically necessary care needed for the children to live at home. In order for a child to qualify for TEFRA, they must require an institutional level of care. They must either require care that is equal to what is provided in an acute care hospital for a minimum of 60 days, or a nursing facility or intermediate care facility for individuals with intellectual disabilities for a minimum of 30 days. It must be appropriate to safely care for the child at home. The estimated cost of care in the home cannot exceed the cost of caring for children in hospitals or the designated facilities. TEFRA may provide children medically necessary services through the SoonerCare program if the above criteria are met.

Please check the appropriate box or boxes below for recommendation of services.

☐ I recommend services be offered if this child is to be cared for in the home.

☐ I do not believe it is in the best interest of the child to receive care in the home.

☐ Yes ☐ No I believe this child's functional limitations are of such a severe nature that I consider him/her to be disabled for a minimum of one year.

Please complete the sections below.

Primary diagnosis for child	ICD-10 CODE
Secondary diagnosis for child	ICD-10 CODE
Diagnosis	ICD-10 CODE
Diagnosis	ICD-10 CODE
Diagnosis	ICD-10 CODE
Diagnosis	ICD-10 CODE

Physician signature : _____ **Date :** _____

Printed Name: _____ **Phone:** _____

Address: _____

Medicaid provider number: _____

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