



### TEFRA/Katie Beckett Care Plan

#### SECTION A: To be completed by parent or legal guardian

##### Personal History

Applicant's Name \_\_\_\_\_ DOB: \_\_/\_\_/\_\_\_\_ Applicant's age \_\_\_\_\_

Applicant's Address \_\_\_\_\_

Applicant's Telephone Number \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_ Quadrant: \_\_\_\_\_

##### Family History

Parent/Guardian #1: \_\_\_\_\_ Parent/Guardian #2: \_\_\_\_\_

Parent/ Guardian Phone: \_\_\_\_\_ Parent/Guardian Email: \_\_\_\_\_

Does Primary Caregiver work?  Yes  No Primary Caregiver's work schedule: Hours: \_\_\_\_\_

Does Secondary Caregiver work?  Yes  No Secondary Caregiver's work schedule: Hours: \_\_\_\_\_

Other siblings: Name(s) \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

##### School Services/Education

Is Child in School?  Yes  No # of hours per day in school: \_\_\_\_\_ # of days per week in school \_\_\_\_\_

Does the child have a:  IFSP or an  IEP?  Yes  No

IFSP Current?  Yes  No

IEP Current?  Yes  No

If yes, (please attach copy to care plan)

##### Level of Care in School:

Skilled Nursing/Number of hours per day: \_\_\_\_\_

Unskilled Nursing (Aide) Number of hours per day: \_\_\_\_\_

Therapies: \_\_\_\_\_

**SECTION B: To be completed by physician(s). Attach additional pages if necessary.**

Primary Care Physician(s) Name: \_\_\_\_\_

Length of time physician has provided care to applicant? \_\_\_\_\_

Primary Care Physician(s) Telephone Number: \_\_\_\_\_

Specialty Physicians: (Name, Specialty, Office Information, Frequency of Visits)

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

**Diagnosis and/or Medical Problems:**

1) \_\_\_\_\_ 2) \_\_\_\_\_

3) \_\_\_\_\_ 4) \_\_\_\_\_

5) \_\_\_\_\_ 6) \_\_\_\_\_

**Medications:** None: \_\_\_\_\_ Medication \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_

Medication: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route \_\_\_\_\_

Medication: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_

Medication: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_

**Medical Information:**

**Problem(s):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Treatment Plan:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Hospitalizations:** \_\_\_\_\_  
\_\_\_\_\_

**Respiratory Care:** N/A \_\_\_\_\_ **Pulse Oximetry:** \_\_\_\_\_ **CPT:** \_\_\_\_\_

**Trach Care:** \_\_\_\_\_ **Suctioning/Frequency:** \_\_\_\_\_

Is recipient on O2?  No  Yes, if so: \_\_\_\_\_ % Hours per day \_\_\_\_\_

Ventilator  During the Day # of Hours: \_\_\_\_\_  During the Night # of Hours \_\_\_\_\_

C-PAP or BI-PAP \_\_\_\_\_ Hours \_\_\_\_\_ ( Please State) Day or Night \_\_\_\_\_

**Nutritional Therapy:**

Nutrition(s): \_\_\_\_\_ Oral/G-Tube/J-tube: \_\_\_\_\_ Frequency: \_\_\_\_\_

I.V. and or TPN Information \_\_\_\_\_

Precautions: \_\_\_\_\_

**Equipment:**

None \_\_\_\_ Wheelchair \_\_\_\_\_ Walking Devices \_\_\_\_\_ Splints \_\_\_\_\_ Other \_\_\_\_\_

**Current Functional Status:**

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**Therapies (Physical, Speech, Occupational, other) include frequency per week and attach therapy notes**

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**Goals and Recommendations:**

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**Letter of Medical Necessity (must be written by the applicant's physician)**

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**SECTION C: Required Services and Equipment (to be completed by physician). Attach additional pages if necessary.**

**Diagnosis:** \_\_\_\_\_

**Short-Term and Long-Term Prognosis:** \_\_\_\_\_

**Estimated monthly utilization of services:** Services that your patient will require or need for in-home care

Services	Frequency	Coverage
Physician services <input type="checkbox"/> Yes <input type="checkbox"/> No Please list all (include CPT codes where applicable):  1. _____  2. _____  3. _____	Number of visits per month per provider:  1. _____  2. _____  3. _____	Is this typically covered by patient's private insurance (if applicable)?  1. <input type="checkbox"/> Yes <input type="checkbox"/> No  2. <input type="checkbox"/> Yes <input type="checkbox"/> No  3. <input type="checkbox"/> Yes <input type="checkbox"/> No
Durable Medical Equipment. List all (include CPT codes where applicable):  4. _____  5. _____  6. _____	How often are replacements needed?  4. _____  5. _____  6. _____	Is this typically covered by patient's private insurance (if applicable)?  4. <input type="checkbox"/> Yes <input type="checkbox"/> No  5. <input type="checkbox"/> Yes <input type="checkbox"/> No  6. <input type="checkbox"/> Yes <input type="checkbox"/> No
Prescription Drugs, list*:  1. _____  2. _____  3. _____ *Please note if brand name required.	Dosage and Frequency:  1. _____  2. _____  3. _____	Is this typically covered by patient's private insurance (if applicable)?  1. <input type="checkbox"/> Yes <input type="checkbox"/> No  2. <input type="checkbox"/> Yes <input type="checkbox"/> No  3. <input type="checkbox"/> Yes <input type="checkbox"/> No

(Continued)

<p>Therapies (include CPT codes where applicable):</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>	<p>Total number of sessions per month:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>	<p>Is this typically covered by patient's private insurance (if applicable)?</p> <p>1. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Skilled Nursing Services <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Number of hours per month:</p>	<p>Is this typically covered by patient's private insurance (if applicable)?</p> <p>1. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Other Services Needed (include CPT codes where applicable):</p> <p>1. _____</p> <p>2. _____</p>	<p>Frequency of these services:</p> <p>1. _____</p> <p>2. _____</p>	<p>Is this typically covered by patient's private insurance (if applicable)?</p> <p>1. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

**SECTION D: Health Information Disclosures (to be completed by parent/guardian)**

I hereby authorize the physician, facility or other health care provider named herein to disclose protected health information and release medical records of the applicant/beneficiary to the Department of Health Care Finance and the Department of Human Services, as may be requested by those agencies, for the purpose of Medicaid eligibility determination.

I also authorize the Department of Health Care Finance and the Department of Human Services to provide information regarding the status of this application to the individuals listed below (for example: applicant's case manager, family member, etc.).

Name	Relationship to Applicant

This authorization expires twelve (12) months from the date signed or when revoked by me, whichever comes first.

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Parent or Legal Guardian's signature/primary

\_\_\_\_\_  
Date

**SECTION E: Signatures**

**A completed Care Plan requires at least two signatures: one of the applicant's primary physicians (who completed this form) and at least one parent/guardian.**

- **Parents or Legal Guardian (Primary) (REQUIRED)**

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Parent or Legal Guardian's signature/primary

\_\_\_\_\_  
Date

- **Physician (REQUIRED-To be valid, physician signature must be dated no more than 30 days prior to the Medicaid application date.)**

\_\_\_\_\_  
Physician Name/ (Print)

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

- **Parents or Legal Guardian (Secondary)**

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Parent or Legal Guardian's signature/primary

\_\_\_\_\_  
Date

**Return this form as part of completed application packet to:**

**Department of Health Care Finance  
Division of Children's Health Services  
Attn: TEFRA/Katie Beckett Coverage Group  
441 4<sup>th</sup> Street NW, Suite 900S  
Washington, DC 20001  
(202) 442-5957**