OKLAHOMA DEPARTMENT OF HUMAN SERVICES

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			

2. Parent/guardian/designated representative contact information.

Last name	First name	MI	Gender ☐ M ☐ F
Street address	City / County / State		Zip
Area code / Phone	Relationship to child		
Primary physician's name	Area code		Phone
Street address	City / State		Zip
Facility/hospital where child last received care			
Street address	City / State		Zip

3. Personal history.

Primary caregiver name	Relationship
Does primary caregiver work? ☐ Yes ☐ No	Caregiver's work schedule, days, hours: Mon _____ Tue _____ Wed _____ Thu _____ Fri _____ Sat _____ Sun _____

Secondary caregiver name	Relationship
Does secondary caregiver work? ☐ Yes ☐ No	Caregiver's work schedule, days, hours: Mon _____ Tue _____ Wed _____ Thu _____ Fri _____ Sat _____ Sun _____

School services education.

Is child in school? ☐ Yes ☐ No	School schedule, days, hours: Mon. _____ Tues. _____ Wed. _____ Thu _____ Fri. _____

Does the child have:

- ☐ Individual Education Plan (IEP)
- ☐ Individual Health Service Plan (IHSP)
- ☐ Individual Family Service Plan (IFSP)

Is IFSP current? ☐ Yes ☐ No If yes, submit with this form.

School services

Type of service/therapy	Days, hours: Mon _____ Tue _____ Wed _____ Thu _____ Fri _____
Type of service/therapy	Caregiver's work schedule, days, hours: Mon _____ Tue _____ Wed _____ Thu _____ Fri _____

4. **Medications.** Attach additional sheets if needed.

Name	Dose	Route	Frequency

Injections: name	Dose	Frequency

5. Home services provided.

Nursing care provider		Area code	Phone
Street address	City	State	Zip
Describe nursing care provided			
Monthly cost $	Days, hours: Mon. _____ Tues. _____ Wed. _____ Thur. _____ Fri. _____		
Physical therapy provider		Area code	Phone
Street address	City	State	Zip
Describe physical therapy provided			
Monthly cost $	Days, hours: Mon. _____ Tues. _____ Wed. _____ Thur. _____ Fri. _____		
Occupational therapy provider		Area code	Phone
Street address	City	State	Zip
Describe occupational therapy provided			
Monthly cost $	Days, hours: Mon. _____ Tues. _____ Wed. _____ Thur. _____ Fri. _____		
Speech therapy provider		Area code	Phone
Street address	City	State	Zip
Describe speech therapy provided			
Monthly cost $	Days, hours: Mon. _____ Tues. _____ Wed. _____ Thur. _____ Fri. _____		
Other therapy provider		Area code	Phone
Street address	City	State	Zip
Describe other therapy provided			
Monthly cost $	Days, hours: Mon. _____ Tues. _____ Wed. _____ Thur. _____ Fri. _____		

6. Home care needs.

Respiratory care Monthly cost $ _____

☐ Pulse Oximetry ☐ CPT ☐ Trach care/suctioning frequency: _____
Is child on oxygen? ☐ Yes ☐ No If yes: % O2 _____
Hours/day on oxygen _____ Ventilator: ☐ Hours/day: _____
☐ C-PAP ☐ BI-PAP Hours: ☐ Day _____ ☐ Night _____

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 $

7. Equipment rental.

Wheelchair provider	Area code	Phone	Monthly cost $
Street address	City	State	Zip
Hospital bed provider	Area code	Phone	Monthly cost $
Street address	City	State	Zip
Patient lift provider	Area code	Phone	Monthly cost $
Street address	City	State	Zip
Oxygen equipment provider	Area code	Phone	Monthly cost $
Street address	City	State	Zip
Oxygen monitor provider	Area code	Phone	Monthly cost $
Street address	City	State	Zip

Apnea monitor provider		Area code	Phone	Monthly cost $
Street address	City		State	Zip
Ventilator/respiratory equipment provider		Area code	Phone	Monthly cost $
Street address	City		State	Zip
Special mattress provider		Area code	Phone	Monthly cost $
Street address	City		State	Zip
Bath equipment provider		Area code	Phone	Monthly cost $
Street address	City		State	Zip
Other medical equipment provider		Area code	Phone	Monthly cost $
Street address	City		State	Zip
Other medical equipment provider		Area code	Phone	Monthly cost $
Street address	City		State	Zip

8. **Personal care.** Complete if currently receiving OKDHS personal care.

Provider's work schedule, days, hours: Mon. _____ Tues. _____ Wed. _____ Thur. _____ Fri. _____ Sat. _____ Sun. _____

9. **Transportation.** Describe any special transport needs related to frequency, vehicle type, expense, time, etc.

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

Parent/guardian signature Date

10. **Physician recommendation:** To be completed by a licensed physician.

Primary diagnosis for child

Secondary diagnosis for child

The level of care the child needs would normally be provided in a:

Check only one: ☐ intermediate care facility for the mentally retarded
☐ nursing facility
☐ hospital

☐ I recommend these 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 any of the above levels of care in the home.

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

Physician signature	Date
Printed name	Phone
Address	Medicaid provider number

11. Completed by OKDHS.

Application date	Requested approval date	Child's ID number	Case number

Is child employed part-time? ☐ Yes ☐ No
If yes, give details.

U.S. citizen or lawful permanent resident? ☐ Yes ☐ No

Date of entry into the U.S. if alien	Highest grade completed to date

Disability decision needed ☐ Yes ☐ No

If yes, attach copies of any recent admit/discharge summaries, lab/x-ray reports, doctors notes and/or statements substantiating child's medical condition for disability.

If child has a diagnosis of mental retardation also attach a psychological evaluation, containing IQ scores and a developmental history summary, completed within the past year by a licensed psychologist.

Additional worker information and comments:

OKDHS worker signature	Date	Phone