TEFRA/KATIE BECKETT CARE PLAN INSTRUCTIONS FOR COMPLETION

This section provides detailed instructions for completion of the TEFRA/Katie Beckett Care Plan. **Note: Please make sure all areas are completed. If a section is not applicable, please mark the Section (N/A). This will assist in a timely review by the Contractor's staff of the applicant's case. If all sections are completed, staff will know that the individuals completing the Care Plan reviewed the entire form.**

SECTION A:

Section identifying information – the Parent or Legal Representative should complete this Section. The (DFCS) office staff make sure Section (A) is completed correctly.

Personal History

Enter the complete name, address, date of birth, age, telephone number, the applicant's city, state, zip code, and county of application. Enter the applicant's Social Security number, if provided.

Medicaid Identification Number

Enter the Medicaid number exactly as it appears on the Medicaid card or Form 962. A valid Medicaid number will be formatted in one of three ways:

a. If the member or applicant is in the Medicaid System, the ID number will be the 12-digit number, e.g., 111222333444;

b. If the member or applicant was previously determined eligible by DFCS staff or making application for services, the number will be the 9-digit SUCCESS number plus a "P", e.g., 123456789P; or

c. If the individual is eligible for Medicaid due to the receipt of Supplemental Security Income (SSI), the number will be the 9-digit Social Security number plus an "S", e.g., 123456789S.

Applicant's Family History

Enter the name of the applicant's parents or legal representative(s). Enter information regarding parent's or legal representative's education and work history. Please indicate if the Primary and Secondary Caregivers work by checking the appropriate box. Enter the work schedule of the Primary and Secondary Caregivers. Also enter the names of other siblings in the household or the family.

School Services/Education
Does the applicant attend school?
Please check the appropriate box and the number of hours per day and days per week, if appropriate.

Is there an Individualized Family Service Plan (IFSP) or Individualized Educational Plan (IEP)? If the response is yes, please submit a copy of the plan with the application.

Level of Care in School
Please check the appropriate boxes if the applicant is receiving nursing hours in school. Indicate the number of hours per day. Complete information regarding therapies received in school.

SECTION B:
Medical Information –the Physician must complete This Section

Please enter the name of the Primary Care Physician for the applicant. If a specialty physician is also treating the applicant, enter that physician(s) name(s)and telephone number.

Applicant's detailed medical history. (Medical records or Transfer Record may be Attached).

Applicant's Diagnosis: In the appropriate lines, describe the primary, secondary, and any third diagnoses relevant to the applicant's condition.

List **medications** and information regarding dosage type & frequency.
Names of drugs with dosages, routes, and frequencies of administration are to be included.

Diagnosis and treatment procedures required.
Medical Information problems - treatment plan
Hospital history
Nutritional history
Equipment needs

- Current Functional Status - Is applicant ambulatory, if applicable, etc.
- Therapies required. Physician's order must accompany therapies.
- Physician's goals and recommendations (Should be stated clearly).
- Physician's Letter of Medical Necessity (Should state the reason why the applicant qualifies for the TEFRA – medical documentation required.

Signatures

- Complete the date the application was signed by physician.
- Enter the date that the attending or admitting physician signs the form.
- Complete the date the application was signed by parent or legal representative.
- Complete the date the application was signed by Social Service Child Protection worker (SSCM), if the child is in state custody.