



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 <input type="checkbox"/> M <input type="checkbox"/> F
Date of birth	Social Security number		Race	Area code	Phone
Current residence <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Caregiver's work schedule, days, hours: Mon _____ Tue _____ Wed _____ Thu _____ Fri _____ Sat _____ Sun _____	

Secondary caregiver name		Relationship	
Does secondary caregiver work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Caregiver's work schedule, days, hours: Mon _____ Tue _____ Wed _____ Thu _____ Fri _____ Sat _____ Sun _____		

School services education.

Is child in school? <input type="checkbox"/> Yes <input type="checkbox"/> No	School schedule, days, hours: Mon. _____ Tues. _____ Wed. _____ Thu _____ Fri. _____
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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 \$
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Ostomy care

Describe care provided	Monthly cost \$
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Nutritional care

Check all that apply <input type="checkbox"/> Oral/G-tube/J-Tube <input type="checkbox"/> Enteral <input type="checkbox"/> 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. _____
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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
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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
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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
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