TEFRA/Katie Beckett Care Plan

Instructions: Parent(s)/guardian(s) must complete **Sections A, D** and sign **Section E** of this form. Medical providers must complete **Sections B, C** and sign **Section E** of this form. Once completed, please return this form as part of completed application packet to the DC Department of Health Care Finance.

- **By Mail:**
  Department of Health Care Finance
  Division of Children's Health Services
  Attn: TEFRA/Katie Beckett
  441 4th Street NW, Suite 900S
  Washington, DC 20001
  (202) 442-5957
- **By Email at HealthCheck@dc.gov**

SECTION A: To be completed by parent or legal guardian			
Personal Information			
Applicant's Name:		DOB:	Applicant's age:
Applicant's Telephone Number:			
Applicant's Address: **Street**			
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 days per week in school	
# of hours per day in school:			
Does the child have an IFSP or an IEP? ☐ Yes ☐ No If yes, which one? _____		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:

_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

Goals and Recommendations:

_____
_____
_____

_____
_____

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

_____
_____
_____
_____
_____
_____

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 ☐ Yes ☐ 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. ☐ Yes ☐ No 2. ☐ Yes ☐ No 3. ☐ Yes ☐ No
Durable Medical Equipment. List all (include CPT codes where applicable): 1. _____ 2. _____ 3. _____	How often are replacements needed? 1. _____ 2. _____ 3. _____	Is this typically covered by patient's private insurance (if applicable)? 1. ☐ Yes ☐ No 2. ☐ Yes ☐ No 3. ☐ Yes ☐ No
Prescription Drugs, list*:	Dosage and Frequency:	Is this typically covered by patient's private insurance (if applicable)?

1. _____ 2. _____ 3. _____ *Please note if brand name required.	1. _____ 2. _____ 3. _____	1. ☐ Yes ☐ No 2. ☐ Yes ☐ No 3. ☐ Yes ☐ No
Therapies (include CPT codes where applicable): 1. _____ 2. _____ 3. _____	Total number of sessions per month: 1. _____ 2. _____ 3. _____	Is this typically covered by patient's private insurance (if applicable)? 1. ☐ Yes ☐ No 2. ☐ Yes ☐ No 3. ☐ Yes ☐ No
Skilled Nursing Services: ☐ Yes ☐ No	Number of hours per month: _____	Is this typically covered by patient's private insurance (if applicable)? ☐ Yes ☐ No
Other Services Needed (include CPT codes where applicable): 1. _____ 2. _____ 3. _____	Frequency of these services: 1. _____ 2. _____ 3. _____	Is this typically covered by patient's private insurance (if applicable)? 1. ☐ Yes ☐ No 2. ☐ Yes ☐ No 3. ☐ Yes ☐ No

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:	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:	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:	Date: