TEFRA/Katie Beckett

Cost-Effectiveness Form

(Child's physician must complete Form)

The following information is requested for the purpose of determining your patient's eligibility for Medicaid:

Patient's Name:_____ Medicaid #:_____

Diagnosis:_____

Prognosis:_____

Please provide the estimated **monthly** costs of Medicaid services your patient will need or is seeking for Medicaid to cover for in-home care:

- Physician's services $_____
- Durable medical equipment _____
- Drugs _____
- Therapy(s) _____
- Skilled Nursing Services _____
- Other(s)_____ _____

TOTAL $_____

Will home care be as good or better than institutional care?

_____ Yes _____ No

COMMENTS:

_____

_____

_____

_____

PHYSICIAN'S SIGNATURE _____

DATE: _____

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