TEFRA/KATIE BECKETT WORKSHEET

A/R's SSN:_____ Date: _____

A/R's Name:_____ Medicaid #:_____

For purposes of cost comparison, check the medical institution as indicated by GMCF on the LOC letter: (select one)

Hospital: ____

NH: _____

Facility for Mentally Retarded:_____

Name and address of the physician who will complete Form DMA-6(A):

_____

_____

Date of trial budget completed by DFCS showing financial ineligibility for SSI:_____

OR

Date of SSI application:_____ Date of SSI denial:_____

Date of SSI approval:_____ Date of SSI termination:_____

CASEWORKER CHECKLIST	Date Requested	Date Received
• Form DMA-6(A)	_____	_____
• Cost-Effectiveness Form		
• Care Plan		
• Disability/SMEU packet		
• Estimated cost of medical institution		
• Psychological (if indicated)		
• Therapy Notes (if indicated)		
• IFSP (if indicated)		
• IEP (if indicated)		
• Other		

Monthly Medicaid Billing Rate of institution: $_____

Estimated cost of in-home care: _____

Estimated Savings: $_____