ARKANSAS DEPARTMENT OF HUMAN SERVICES
TEFRA Waiver
Physician Assessment of Eligibility

Date of Application _____

SECTION I. Patient Information:

PATIENT'S LAST NAME	FIRST	MI	SEX ☐ M ☐ F	PATIENT'S MEDICAID ID#
PHONE NUMBER	COUNTY OF RESIDENCE	DATE OF BIRTH	RACE	SOCIAL SECURITY NUMBER
MAILING ADDRESS(Street, City, State, Zip code)		RESIDENCE ADDRESS(Street, City, State, Zip code)		
PRIMARY PHYSICIAN	ADDRESS			
PARENT/GUARDIAN NAME (Primary Caregiver)		CHILD SCREENING REFERRAL ☐ Yes ☐ No		
INSURANCE COMPANY AND ADDRESS		INSURANCE POLICY NUMBER		
☐ Original	☐ Re-certification	Date		
PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	OTHER DIAGNOSIS		
HOSPITALIZATIONS in the last year – Reason and Length of Stay				
BRIEF MEDICAL AND SURGICAL HISTORY (If available, please attach copies of clinical or hospital records)				
☐ Letter Attached ☐ Medical Records Attached				
Prognosis				
Goals				
Date Last Examined				

SECTION II. **Current Services Required for Patient Management:** ***Please attach a current medical & surgical history that includes M.D. summary, prognosis and medical follow-up requirements. Include changes since last certification, if recertification.*** **CHECK ALL THAT APPLY.**

Required Services:

☐ Close patient monitoring of _____ with frequent skilled intervention of
(specific symptom)

_____
(intervention)

☐ Hyperalimentation - parenteral or sole source enteral
☐ IV Drugs (chemotherapy, pain relief or prolonged IV antibiotics)
☐ Respiratory - Tracheostomy Care or continuous Oxygen Supplementation
☐ Ventilator-Dependent: _____ Hours per day

SECTION II. (Continued):

Needs Assessment:

- ☐ Cardiovascular System
- ☐ Digestive System
- ☐ Endocrine System
- ☐ Genito-urinary System
- ☐ Hemic and Lymphatic System
- ☐ Immune System
- ☐ Mental Disorders
- ☐ Multiple Body Systems
- ☐ Musculoskeletal System
- ☐ Neoplastic Diseases
- ☐ Neurological
- ☐ Respiratory System
- ☐ Skin
- ☐ Special Senses and Speech

Physical Abilities/Limitations:

- ☐ Ambulatory
- ☐ Ambulates with assistance
- ☐ Independent transfers bed/chair
- ☐ Transfers with assistance
- ☐ Total lift
- ☐ Sighted
- ☐ Blind
- ☐ Verbal
- ☐ Other _____
- ☐ Deaf
- ☐ Signs
- ☐ Augmentative Communication Device

Cognitive Abilities/Limitations:

- ☐ Alert, cognitive appropriate for age
- ☐ Alert, cognitive age _____
- ☐ Alert, disoriented
  - Bathing: ☐ self ☐ caregiver
  - Feedings: ☐ self ☐ caregiver
- ☐ Unresponsive
- ☐ Uncooperative
- ☐ Other _____

Skilled Nursing Needs: (frequency documented by hospital record or nurse's notes)

- ☐ Continuous O_2
- ☐ Nasopharengeal Suctioning
- ☐ Sole source enteral _____ hrs
- ☐ Trach Care
- ☐ Tracheal Suctioning
- ☐ Ventilator _____ hrs/day
- ☐ _____ (other)
- ☐ _____ (other)
- ☐ _____ (other)

Additional Services:

Medications (route and frequency): _____

Occupational Therapy (frequency, location & provider name): _____

Physical Therapy (frequency, location & provider name): _____

Speech Therapy (frequency, location & provider name): _____

Other – Specify (ex: Personal Care, Waiver Caregiver, Developmental Day Treatment Clinic Services, Mental Health, Home Health, Targeted Case Management): _____

Name of Targeted Case Manager, if applicable: _____

SECTION II. (Continued):

Equipment or Special Physical Aids In Use:

- ☐ Catheter
- ☐ CPAP/BIPAP
- ☐ Crutches/Cane
- ☐ Enteral Pump
- ☐ Hospital Bed
- ☐ Hoyer Lift
- ☐ IV Pump
- ☐ Nebulizer
- ☐ O_2
- ☐ Orthotics/Prosthetics
- ☐ Ostomy care
- ☐ Pulse OX
- ☐ Shower Chair
- ☐ Shower Chair
- ☐ Shower Chair
- ☐ Shower Chair
- ☐ Suction Machine
- ☐ Ventilator
- ☐ Walker
- ☐ Wheelchair: ☐ power ☐ manual

_____

☐ Other _____ ☐ Other _____

Daycare/Education:

Daycare/School Days & Hours, Name of School. List Start/End Dates and Vacation Dates: _____

_____

_____

_____

GOALS:

A. Patient/Family Education/Teaching Goals: _____

_____

_____

_____

B. Were previous goals met? _____

_____

_____

_____

SECTION III. Psycho-Social History:

Please include changes in psycho-social situation since last certification if re-certification.

A. Caregiver's understanding of patient's condition: _____

B. Family composition (List all residents of home by name and age. List education and occupation of Adults): _____

C. Support system: _____

D. Transportation requirements: _____

E. Number of competent caregivers in home (name & relationship to patient): _____

SECTION IV. PHYSICIAN'S CERTIFICATION:

I certify that the above named patient can be treated in a home setting with the services specified in this assessment.

The services are appropriate to the condition of the patient: ☐ Yes ☐ No

Home/Community resources are available for this assessment: ☐ Yes ☐ No

Signature of Physician: _____ Date: _____

Printed Name: _____ Phone: _____

Address: _____

City, State and Zip Code: _____