

TEFRA/KATIE BECKETT CARE PLAN

Section A: To be Completed by Parent or Legal Representative

Personal History:

Applicant's Name: _____ DOB: _____ Applicant's Age _____

Applicant's Address: _____

Applicant's Telephone number _____

City: _____ State: _____ Zip Code: _____ County: _____

Social Security #: _____ Medicaid I.D.# _____

Family History:

Mother's name: _____ Father's name: _____

Mother's Educational level: _____ Father's Educational level: _____

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 hours per day in school: _____ # of days per week in school: _____

Does the child have a: IFSP or an IEP ? Yes No

IFSP Current? Yes No

IEP Current? Yes No

If yes, (submit with application)

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

Primary Care Physician(s) Name: _____

Primary Care Physician(s) Telephone Number: _____

Specialty Physicians: 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: _____
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)

Parent or Legal Representative Signature/Primary

Date

Physician Signature/Primary

Date

Parent or Legal Representative Signature (Secondary)

Date

Social Worker or /DFCS Foster Care Worker

Date

This document requires at least two signatures, the Primary Care Physician or Physician of record and Parent or Legal Representative (Caregiver’s Signature). ** Foster care applicants must have the signature of the DFCS Representative.