TEFRA/KATIE BECKETT
Cost-Effectiveness Form
(Child's Physician Must Complete Form)

The following information is requested to determine your patient's eligibility for Medicaid:

Patient's Name Susie Smith Medicaid #: New application

Diagnosis: Chromosomal abnormality, autism, global developmental delay, hypotonia, macrocephaly

Prognosis: Permanent, but good with intensive therapeutic support

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

- Physician's services $ 500.00
- Durable medical equipment $ 0.00
- Drugs $ 100.00
- Therapy(s) $ 1100.00
- Skilled nursing services $ 0.00
- Other(s)_____ $ _____

TOTAL: $ 1700.00

Will home care be as good as or better than institutional care? ✓ Yes _____ No

Comments: Primary insurance will cover a total of 60 combined therapy visits for the plan year.

Physician's Signature: _____

Date: _____

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