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 __________________________  Medicaid #: __________________________

Diagnosis: __________________________

Prognosis: __________________________

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 $________
- Durable medical equipment $________
- Drugs $________
- Therapy(s) $________
- Skilled nursing services $________
- Other(s) $________

**TOTAL:** $________

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

Comments: __________________________________________________________

__________________________________________________________

__________________________________________________________

Physician’s Signature: __________________________

Date: __________________________

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