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: ____

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Physician's Signature: ____

Date: ____

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