TEFRA Medicaid Plan of Care

☒ Initial Application ☐ Renewal

Care Coordinator Name:	**Care Coordinator Agency and Mailing address:**	**Care Coordinator phone and email address:**
Child's Name:	**Child's Date of Birth:**	**Medicaid ID #:** 060
TF#:		
Child's Physical Address:		
Mailing Address:		
Plan Start Date:	**Plan of Care Expiration Date:**	
Part I: Medical Plan		
Expected Outcomes:	**Services/Service Frequency History:**	
Service Provider Availability:	**Name of Providers:**	
Part II: Educational/Developmental		
Expected Outcomes:	**Services/Service Frequency History:**	
Service Provider Availability:	**Name of Providers:**	
Part III: Individual / Family Supports		
Expected Outcomes:	**Services/Service Frequency History:**	
Service Provider Availability:	**Name of Providers:**	
IV. Other Medicaid Services		
Expected Outcomes:	**Requested Medicaid Services:**	
Services/Service Frequency History:	**Service Provider Availability:**	
Name of Providers:		
V. Parental Acknowledgement/Support:		

I have participated in developing and agree with the Plan of Care for my child: ☐ Yes ☐ No

I am aware of the following responsibilities for continued participation in TEFRA Medicaid:
Completion of the annual Eligibility Review (yellow) form: ☐ Yes ☐ No

Completion of all disability review forms as directed by the Division of Public Assistance (MED 1 and MED 2): ☐ Yes ☐ No

Regularly scheduled appointments with my child's physicians to delay premature institutionalization: ☐ Yes ☐ No

Ongoing Physical Therapy, Occupational Therapy, Speech Therapy, behavioral therapy, or any treatments prescribed to allow my child to reach his or her maximum potential: ☐ Yes ☐ No

Notifying the Division of Public Assistance, Comagine Health and my care coordinator of any change in address, phone or child's financial assets: ☐ Yes ☐ No

Signature of Parent:	**Date Signed:**
Signature of Preparer:	**Date Signed:**
Team Members:	**Discipline:**

VI. Comagine Health Certification (This section to be completed by Comagine Health)

Comagine Health has determined that it is appropriate for this child to be provided cared in the community in lieu of institutional care.

Signature of Comagine Health Nurse:	Date: