TEFRA WAIVER PROGRAM

ARKANSAS DEPARTMENT OF HUMAN SERVICES

The TEFRA Waiver is a cost sharing Medicaid program that enables certain children with a disability to have care in their homes rather than in an institution.

Medical Evaluation Process

Disability, Medical Necessity and Appropriateness of Care are separate determinations that the TEFRA child must meet. Each determination is described below.

Disability:

A child must meet Social Security Administration's (SSA) definition of disabled. If the child received SSI within one year prior to applying for TEFRA and lost benefits due to reasons other than disability, the child meets the disability requirements. If SSA has not established disability, a Medical Review Team (MRT) disability review must be completed. Your local DHS office will request the review for you.

Medical Necessity:

Medical necessity is a separate determination from the disability determination. For medical necessity, the child must have a medical condition that would require institutional placement in an acute care facility, a skilled nursing facility, an ICF/MR facility, an Alternative Home placement or be at risk for future institutional placement. Medical necessity is also based on services that improve, maintain or prevent regression of the child's health status.

Appropriateness of Care:

Medical services that are appropriate to be provided outside of an institution must be available to care for the child in the home. The estimated cost of the care cannot exceed the estimated cost of care for the child in an institution.

TEFRA FACT SHEET

PUB 405 (04/14)

TEFRA Waiver Program Frequently Asked Questions

What is Cost Sharing?

Families of children determined eligible for the TEFRA WAIVER whose annual income after allowable deductions exceeds 150% of the Federal Poverty Level will be required to pay a monthly premium to participate in the program. The premium payment will begin the first month following the month the application is approved. The total annual out-of-pocket cost sharing cannot exceed five percent of the family's gross income.

How is the premium determined?

Whether or not you must pay a premium is based on your household size and annual income as reported to IRS. Allowable deductions include a $600 deduction per dependent child living in the home and excess medical and dental expenses as shown on Schedule A of the parent's federal tax return. Premiums will not be required if annual income is at or below 150% of the Federal Poverty Level. To determine your premium range, find your family size on Chart 1 below. If your annual income after allowable deductions is at or below the amount listed for your household size, you will not be assessed a premium. If your income is greater than the amount listed below for your household size, please continue to Chart 2 to find your premium range.

Chart 1

Family Size	150% FPL
1	$17,505
2	$23,595
3	$29,685
4	$35,775
5	$41,865
6	$47,955
7	$54,045
For each additional member add:	$6,090

CHART 2 TEFRA Cost Share Schedule

Monthly Premium Range				
From	To	%	From	To
$ 0	$ 25,000	0.00%	$ 0	$ 0
$ 25,001	$ 50,000	1.00%	$21	$42
$ 50,001	$ 75,000	1.25%	$52	$78
$ 75,001	$100,000	1.50%	$ 94	$125
$100,001	$125,000	1.75%	$146	$182
$125,001	$150,000	2.00%	$208	$250
$150,001	$175,000	2.25%	$281	$328
$175,001	$200,000	2.50%	$365	$417
$200,001	Unlimited	2.75%	$458	$458

How are premiums collected?

Premium payments are collected by either a monthly bank draft or quarterly advance payments by check or money order. You will choose your payment option preference upon approval of your application. Regardless of the option you choose, the first two-month's premiums must be paid in advance by check or money order.

If you choose the bank draft option, the premium will automatically be drafted from your bank account. If you choose the advance payment option, you will receive monthly invoices in the mail.

www.state.ar.us/dhs/TEFRA
Questions about Medicaid coverage and services call 1-800-482-5431
Questions about Medicaid eligibility call 1-800-482-8988

ARKANSAS DEPARTMENT OF HUMAN SERVICES
TEFRA and AUTISM WAIVER
Application for Assistance

If you need this material in a different format, such as large print, please contact your local DHS county office.
Si necesita este formulario en Espanol, llame al 1-800-482-8988 y pida la versión en Español.

What type of services are you requesting? **TEFRA** **Autism Waiver**

Child's Name:	Social Security Number	Male Female	U.S. Citizen Yes No
Date of Birth:	Age: _____years _____months	Race:	
Parent/Guardian:			
Current Address: City:	State:	Zip:	County:
Phone:	Email:		

1. **Does the child you are applying for have income? Yes No If yes, list the child's income below.**

Source of Income	Gross Amount (Before deductions)	How often?
Social security		
SSI		
Veteran's benefits		
Child support		
Other		

2. **Does the child you are applying for have resources? Yes No If yes, list the child's resources.**

Source of Resource	Amount or Value	Location of Resource
Cash, Checking, Savings or Christmas Club Account		
Stocks, Bonds, Trust Fund, Certificate of Deposit, Mutual Fund, etc.		
Other		

3. **Does the child you are applying for have health insurance? Yes No**
   If yes, please provide a copy of the front and back of the child's insurance card.

4. **Primary Care Physician** _____

   Autism Diagnosis Yes No Date of Diagnosis _____

5. **Do you expect a change in any of the above? Yes No If yes, what?** _____
   When? _____

For TEFRA only

Information needed to determine the TEFRA premium:

- Please attach the most recent Federal Income Tax Return and Schedule A, if you itemized deductions, for the child's parent(s).
- The total number of dependents that live in your household including yourself: _____

For Autism Waiver only

If this application is for the Autism Waiver, please attach an evaluation report from each of the following indicating that the child has a diagnosis of autism. Please place a check mark beside each item that is attached.

Physician Report
Psychologist Report
Speech-language Pathologist Report
Adaptive Behavior Assessment Report (such as Vineland)

Read carefully before you sign this application

The PRIVACY ACT of 1974 requires the Department of Human Services (DHS) to tell you: (1) whether disclosure of your SSN is voluntary or mandatory; (2) How DHS will use your SSN; and (3) The law or regulation that allows DHS to ask you for the SSN. We are authorized to collect from your household certain information including the social security number (SSN) of each eligible household member. For the TEFRA and Autism Program, this authority is granted under Federal Laws codified at 42 U.S.C. §§1320b-7(a) (1) and 1320b-7(b) (2). This information may be verified through computer matching programs. We will use this information to determine program eligibility, to monitor compliance with program rules, and for program management. This information may be disclosed to other Federal and State agencies and to law enforcement officials. If a claim arises against your household, the information on this application, including all SSNs, may be provided to Federal or State officials or to private agencies for collection purposes. * EXCEPTION: In the Medicaid Program, information is disclosed without the individual's written consent only to: authorized employees of this Agency, the Social Security Administration, the U.S. Department Of Health and Human Services, the individual's attorney, legal guardian, or someone with power of attorney; or an individual who the recipient has asked to serve as his representative AND who has supplied confidential information for the case record which helped to establish eligibility, or court of law when the case record is subpoenaed.

- I understand that I must help establish my eligibility by providing as much information as I can and in some situations I may be required to provide proof of my circumstances.
- I authorize the Department of Human Services (DHS) to obtain information from other state agencies and other sources to confirm the accuracy of my statements.
- I understand Social Security Numbers (SSNs) will be used in a computer match to detect and prevent duplicate participation. SSNs are also used in a match through the State Income and Eligibility Verification System to secure wage, unearned income and benefit information from the Social Security Administration, Department of Workforce Services, and Internal Revenue Service. Information received may be verified through other contacts when discrepancies are found by DHS and may affect eligibility or level of benefits.
- I understand that no person may be denied Medicaid benefits on the grounds of race, color, sex, age, disability, religion, national origin, or political belief.
- I may request a hearing from DHS if a decision is not made on my case within the proper time limit or if I disagree with the decision.
- I agree to notify the DHS county office within 10 days if I or any of my dependents cease to live in my home, if I move, or if any other changes occur in my circumstances.
- I authorize DHS to examine all records of mine or records of those who receive or have received Medicaid benefits through me to investigate whether or not any person has committed Medicaid fraud, or for use in any legal, administrative or judicial proceeding.

Assignment of Medical Support. I authorize any holder of medical or other information about me to release information needed for an Medicaid claim to DHS. I further authorize release of any information to other parties who may be liable for my medical expenses. As an eligibility condition, I automatically assign my right to any settlement, judgment, or award which may be obtained against any third party to DHS to the full extent of any amount which is paid by DHS for my behalf. I authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tortfeasors or insurers arising out of an Medicaid claim, be paid directly to DHS. My application for Medicaid benefits shall in itself constitute an assignment by operation of law and shall be considered a statutory lien of any settlement, judgment, or award received by me from a third party. A third party is any person, entity, institution, organization or other source who may be liable for injury, disease, disability or death sustained by me or others named herein, including estates of said individuals. I also assign all rights in any settlement made by me or on my behalf arising out of any claim to the extent medical expenses paid by DHS, whether or not a portion of such settlement is designated for medical expenses. Any such funds received by me shall be paid to DHS. A copy of this authorization may be used in place of the original.

I DECLARE UNDER PENALTY OF PERJURY THAT THE ABOVE IS TRUE AND CORRECT. If I receive benefits to which I am not entitled because I withheld information or provided inaccurate information, such assistance will be subject to recovery by the Department of Human Services, and I may be subject to prosecution for fraud and fined and/or imprisoned.

Signature _____ Date _____

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
TEFRA Waiver
Physician Assessment of Eligibility

Date of Application _____

SECTION I. Patient Information:

PATIENT'S LAST NAME	FIRST	MI	SEX ☐ M ☐ F	PATIENT'S MEDICAID ID#
PHONE NUMBER	COUNTY OF RESIDENCE	DATE OF BIRTH	RACE	SOCIAL SECURITY NUMBER
MAILING ADDRESS(Street, City, State, Zip code)		RESIDENCE ADDRESS(Street, City, State, Zip code)		
PRIMARY PHYSICIAN	ADDRESS			
PARENT/GUARDIAN NAME (Primary Caregiver)		CHILD SCREENING REFERRAL ☐ Yes ☐ No		
INSURANCE COMPANY AND ADDRESS		INSURANCE POLICY NUMBER		
☐ Original	☐ Re-certification	Date		
PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	OTHER DIAGNOSIS		
HOSPITALIZATIONS in the last year – Reason and Length of Stay				
BRIEF MEDICAL AND SURGICAL HISTORY (If available, please attach copies of clinical or hospital records)				
☐ Letter Attached	☐ Medical Records Attached			
Prognosis				
Goals				
Date Last Examined				

SECTION II. **Current Services Required for Patient Management:** ***Please attach a current medical & surgical history that includes M.D. summary, prognosis and medical follow-up requirements. Include changes since last certification, if recertification.*** **CHECK ALL THAT APPLY.**

Required Services:

☐ Close patient monitoring of _____ with frequent skilled intervention of
(specific symptom)

_____
(intervention)

☐ Hyperalimentation - parenteral or sole source enteral

☐ IV Drugs (chemotherapy, pain relief or prolonged IV antibiotics)

☐ Respiratory - Tracheostomy Care or continuous Oxygen Supplementation

☐ Ventilator-Dependent: _____ Hours per day

SECTION II. (Continued):

Needs Assessment:

- ☐ Cardiovascular System
- ☐ Digestive System
- ☐ Endocrine System
- ☐ Genito-urinary System
- ☐ Hemic and Lymphatic System
- ☐ Immune System
- ☐ Mental Disorders
- ☐ Multiple Body Systems
- ☐ Musculoskeletal System
- ☐ Neoplastic Diseases
- ☐ Neurological
- ☐ Respiratory System
- ☐ Skin
- ☐ Special Senses and Speech

Physical Abilities/Limitations:

- ☐ Ambulatory
- ☐ Ambulates with assistance
- ☐ Independent transfers bed/chair
- ☐ Transfers with assistance
- ☐ Total lift
- ☐ Sighted
- ☐ Blind
- ☐ Verbal
- ☐ Other _____
- ☐ Deaf
- ☐ Signs
- ☐ Augmentative Communication Device

Cognitive Abilities/Limitations:

- ☐ Alert, cognitive appropriate for age
- ☐ Alert, cognitive age _____
- ☐ Alert, disoriented
  - Bathing: ☐ self ☐ caregiver
  - Feedings: ☐ self ☐ caregiver
- ☐ Unresponsive
- ☐ Uncooperative
- ☐ Other _____

Skilled Nursing Needs: (frequency documented by hospital record or nurse's notes)

- ☐ Continuous O_2
- ☐ Nasopharengeal Suctioning
- ☐ Sole source enteral _____ hrs
- ☐ Trach Care
- ☐ Tracheal Suctioning
- ☐ Ventilator _____ hrs/day
- ☐ _____ (other)
- ☐ _____ (other)
- ☐ _____ (other)

Additional Services:

Medications (route and frequency): _____

Occupational Therapy (frequency, location & provider name): _____

Physical Therapy (frequency, location & provider name): _____

Speech Therapy (frequency, location & provider name): _____

Other – Specify (ex: Personal Care, Waiver Caregiver, Developmental Day Treatment Clinic Services, Mental Health, Home Health, Targeted Case Management): _____

Name of Targeted Case Manager, if applicable: _____

SECTION II. (Continued):

Equipment or Special Physical Aids In Use:

- ☐ Catheter
- ☐ CPAP/BIPAP
- ☐ Crutches/Cane
- ☐ Enteral Pump
- ☐ Hospital Bed
- ☐ Hoyer Lift
- ☐ IV Pump
- ☐ Nebulizer
- ☐ O_2
- ☐ Orthotics/Prosthetics

_____

☐ Other _____

- ☐ Ostomy care
- ☐ Pulse OX
- ☐ Shower Chair
- ☐ Shower Chair
- ☐ Shower Chair
- ☐ Shower Chair
- ☐ Suction Machine
- ☐ Ventilator
- ☐ Walker
- ☐ Wheelchair: ☐ power ☐ manual

☐ Other _____

Daycare/Education:

Daycare/School Days & Hours, Name of School. List Start/End Dates and Vacation Dates: _____

_____

_____

_____

GOALS:

A. Patient/Family Education/Teaching Goals: _____

_____

_____

_____

B. Were previous goals met? _____

_____

_____

_____

SECTION III. Psycho-Social History:

Please include changes in psycho-social situation since last certification if re-certification.

A. Caregiver's understanding of patient's condition: _____

_____

_____

B. Family composition (List all residents of home by name and age. List education and occupation of Adults): _____

_____

_____

C. Support system: _____

_____

_____

D. Transportation requirements: _____

_____

E. Number of competent caregivers in home (name & relationship to patient): _____

_____

SECTION IV. PHYSICIAN'S CERTIFICATION:

I certify that the above named patient can be treated in a home setting with the services specified in this assessment.

The services are appropriate to the condition of the patient: ☐ Yes ☐ No

Home/Community resources are available for this assessment: ☐ Yes ☐ No

Signature of Physician: _____ Date: _____

Printed Name: _____ Phone: _____

Address: _____

City, State and Zip Code: _____