Arkansas Department of Human Services
TEFRA Waiver Program
Premium Notification

Dear TEFRA Recipient:

This letter is notification of your TEFRA Waiver premium amount and the monthly payment options. You will also receive periodic Premium Invoice and Statement of Account forms.

Your monthly TEFRA waiver premium is ___(premium amount)__. An initial payment for your first two months premium (for the months of XXX and XXX) is due upon receipt. Total amount due is _____. Future payments will be made based on the payment option you select.

Your TEFRA Account Number is:_____
You will need to enter your TEFRA Account Number on the Premium Payment Selection Form and on personal checks and money orders. Make your check or money order payable to: *TEFRA Premium Unit*.

ENCLOSED ARE THE FOLLOWING:

1) TEFRA Waiver Program Premium Payment Selection form. You are asked to choose your method of future payments. Please complete this form and attach the appropriate documentation and return in the envelope supplied.

2) Pre-paid business reply envelope for your convenience in returning your initial payment and your TEFRA Waiver Premium Payment Selection form.

If you choose to pay by monthly bank draft, your bank account will be drafted on the first business day of each month. If you choose to pay by check or money order, you will be required to remit payments on a quarterly basis. You will receive a monthly Invoice and Statement.

The bank that will process premium payment checks and monthly bank drafts on behalf of DHS will charge $28.00 for check overdrafts and up to $5.25 for failed monthly bank drafts. These fees, if assessed, will be shown on the monthly Premium Invoice and Statement of Account form.

If you need assistance in completing the forms or if you have any questions please contact the TEFRA Premium Unit at their toll free number, 1-866-239-9938.

Sincerely,

TEFRA Premium Unit

Arkansas Department of Human Services

TEFRA Waiver Program
Premium Payment Selection Form

Section I: Complete this section

Recipient's Name_____ Name of Parent or Guardian_____

TEFRA Account Number (This number is on the Premium Notification form.) _____

I prefer to make payment by: ☐ Monthly Bank Draft (*Must be paid in advance*) ☐ Quarterly personal check, or money order *(Must be paid in advance)*

*If "**Quarterly**" was checked, sign here and do not complete Sections II and III.*

_____ _____
Signature of Parent or Guardian Date

Section II: Complete this section only if the premium payments will be made by Monthly Bank Draft

Name(s) on Bank Account:_____

Address_____ Telephone Number _____

City, State_____ Zip Code _____

Name of Bank _____

Bank Address _____

City, State _____ Zip Code _____

ABA Transit Number _____ Bank Account Number _____

(The ABA transit number is the number preceding the bank account number on your check)

A VOIDED CHECK or SAVINGS DEPOSIT SLIP IS REQUIRED TO VERIFY THESE NUMBERS.

This Bank Account Number is for a ☐ Checking Account ☐ Savings Account
(If not indicated, checking will be automatically entered)

Section III: Complete this section only if the TEFRA waiver premium payments will be made by Monthly Bank Draft. Read this statement, then sign and date.

I hereby authorize the Arkansas Medicaid Program/Title XIX to initiate debit entries to my bank account as indicated above and the bank named above to debit the same to such account. I understand I am responsible for the accuracy of the information that I have supplied on this form.

_____ _____
Bank Account Holder's Signature (required) Date

Arkansas Department of Human Services
TEFRA Waiver Program
Correction of Premium Payment Information

Recipient's Name_____ Parent or Guardian's Name_____

TEFRA Account Number:

YOUR 'MONTHLY BANK DRAFT' TRANSACTION WAS UNSUCCESSFUL DUE TO THE FOLLOWING:

____Invalid ABA Number – (Number currently on file)_____

Please supply correct ABA Number_____
(Attach a voided check or savings deposit slip.)

____Invalid Bank Account Number – (Number currently on file) _____

Please supply correct Bank Account Number _____
(Attach a voided check or savings deposit slip.)

_____ _____
Signature of Parent of Guardian Date

Please send this correction form to the address below within 10 business days from _____ to avoid any interruption in your TEFRA Waiver coverage. Please return this form to:

Financial Unit
Attn: TEFRA Processing
P.O. Box **XXXX**
Little Rock, AR 72203

If you have any questions or need assistance in completing this form please call the TEFRA Premium Unit at their toll free number, 1-866-239-9938. Thank you for your assistance in this process.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
TEFRA Waiver Program
Premium Invoice and Statement of Account

SEND/MAKE CHECK/MONEY ORDER PAYABLE TO:
TEFRA Premium Unit
P.O. Box XXXX
Little Rock, AR 72003

Date TEFRA Account #

Amount Enclosed $_____

TEFRA Family Name
1234 Jones Drive
Anywhere, AR 72203

*IF YOU HAVE ANY **QUESTIONS** CALL THE TEFRA PREMIUM UNIT AT THEIR TOLL FREE NUMBER 1-866-239-9938.*

CHANGES: Check appropriate box.

[ ] Address changed. Enter the new address beside the old address.

[ ] Bank Account information has changed. New bank name _____

Address (St., City, State, Zip)_____

New ABA transit No._____New bank Acct. No. _____

Attach a voided check or savings deposit slip.

Signature of Bank Account Holder_____Date_____

[ ] Change premium payment frequency to monthly bank draft. (Enter bank information in the bank spaces above and *attach a voided check or savings deposit slip*.) I authorize monthly bank drafts.

Signature of Bank Account Holder_____Date_____

[ ] Change premium payment frequency from monthly bank draft to quarterly checks or money orders and cancel bank draft authorization.

Signature of Parent or Guardian_____Date_____

PLEASE DETACH AND RETURN TOP PORTION WITH PAYMENT

Date	Reference	Description	Amount	Balance Due
		Due Date		
			Total Due:	
Current	**31-60 Days**	**61-90 Days**	**Over 90 Days**	

ARKANSAS DEPARTMENT OF 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 _____ (specific symptom) with frequent skilled intervention of _____ (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
- ☐ Ostomy care
- ☐ Pulse OX
- ☐ Shower Chair
- ☐ Shower Chair
- ☐ Shower Chair
- ☐ Shower Chair
- ☐ Suction Machine
- ☐ Ventilator
- ☐ Walker
- ☐ Wheelchair: ☐ power ☐ manual

_____

☐ Other _____ ☐ 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: _____