SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

TEFRA
In-Home Care Certification

This box for SCDHHS Use Only Case HH#: ____________

This form is to be completed by the applicant's physician. Certification that the applicant may be cared for in a home setting, even though his/her medical condition may warrant acute or institutional care, is a requirement for Medicaid eligibility under the TEFRA program and in no way holds the physician responsible for the applicant's in-home care.

APPLICANT INFORMATION

Applicant Name (First, Middle, Last) (Print)		Phone	
Street Address	City	State	ZIP
Medicaid ID (if applicable)	Date of Birth	Social Security Number	

PHYSICIAN INFORMATION

Physician Name (First, Middle, Last) (Print)			
Street Address	City	State	ZIP
Phone	Fax		

PHYSICIAN'S STATEMENT

As of the date listed below, I agree that it is appropriate to provide care at home for:

____________________________________ (Child's full name).

____________________________________ Physician's Signature

____________________ Date

ROUTING INSTRUCTIONS

MAIL TO: SCDHHS - Central Mail
PO Box 100101
Columbia, SC 29202

OR

FAX TO: (803) 255-8236

NOTE

Questions regarding the completion of this statement or the TEFRA program should be directed to the South Carolina Department of Health and Human Services at (888) 549-0820.