SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 100101
Columbia, South Carolina 29202-3101

TEFRA IN-HOME CARE CERTIFICATION

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.

To: _____**, Medicaid Eligibility Worker**

_____

_____

_____

From: _____**, M.D.**

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)***

_____
(Physician's address)

_____ _____
(City, State, Zip Code) ***(Area Code/Telephone Number)***

ROUTING INSTRUCTIONS:
- **Forward the completed form to the Medicaid eligibility worker at the address listed above.**
- **Form must be filed in the applicant's Medicaid case folder.**

NOTE: Questions regarding the completion of this statement or the TEFRA program should be directed to the Bureau of Eligibility Policy and Oversight within the South Carolina Department of Health and Human Services, (803) 898-2635.

DHHS Form 3291 ME (Oct 04)