

REQUEST FOR MEDICAL ELIGIBILITY DETERMINATION

I. RECIPIENT INFORMATION

A. Recipient's Name:		SS #:	Medicaid #:
B. Address (City, State, Zip Code, Parish):		C. Responsible Party/Curator:	
		Address (City, State, Zip Code, Parish):	
Telephone #:	Race:	Sex:	
Medicare #:	Date of Birth:	Relationship:	Telephone #:
D. What are/were the living arrangements: <input type="checkbox"/> Own home <input type="checkbox"/> Relative's home <input type="checkbox"/> Other			
E. What previous institutional care (including nursing facilities) has this person received?			
Facility:	Date:	Facility:	Date:
Facility:	Date:	Facility:	Date:
F. What Home/Community-based services have been used/considered: <input type="checkbox"/> ADHC <input type="checkbox"/> MR/DD <input type="checkbox"/> CC <input type="checkbox"/> PCA <input type="checkbox"/> ELDERLY <input type="checkbox"/> HH			
G. Why were services not suitable?			
H. Requesting Nursing Home placement: <input type="checkbox"/> Temporarily <input type="checkbox"/> Permanently			
I. Applicant/Responsible Party Signature: _____ Date: _____			

II. LEVEL OF CARE DETERMINATION

Institutional care is provided under classifications dependent upon the type and/or complexity of care and services rendered, as well as, the amount of time required to render the necessary care and services. The attending physician must designate the required level of care by selecting the appropriate level below. This requirement also applies to applicants requesting home or community-based waiver services to allow for a determination of the level of institutional care that would otherwise be required. Please select one of the following levels of care:

A. Intermediate Care II (minimum care required) - Includes some aid in activities of daily living, diversionary activities, protection from hazards and/or a minimum

B. Intermediate Care I (medium care required) - Includes need for nursing care to manage a plan of care and/or more assistance with extensive personal care, ambulation, and mobilization.

C. Skilled Care (maximum care required) - Indicate special level, if indicated: TDC ID NRTP (Complex; Rehab) Includes professional nursing care and assessment on a daily basis due to a serious condition which is unstable or a rehabilitative therapeutic regime requiring professional staff.

D. ICF/MR - Requires active treatment of mental retardation or a developmental disability under supervision of a qualified mental retardation or developmental disability professional.

E. Is this person likely to need services in a medical facility (hospital, nursing facility, etc.) for at least thirty (30) consecutive days ? Yes No

F. Home/community based services are adequate to meet the needs of this patient. Yes No

G. COMMENTS:

III. MEDICAL INFORMATION

Recipient's Name: _____

A. Diagnosis: _____

B. Medications:(Specify dosage, frequency, and route) ALLERGIES _____

- | | | |
|----------|----------|-----------|
| 1. _____ | 5. _____ | 9. _____ |
| 2. _____ | 6. _____ | 10. _____ |
| 3. _____ | 7. _____ | 11. _____ |
| 4. _____ | 8. _____ | 12. _____ |

C. Recent Hospitalizations: (include psychiatric) _____

D. Mental Status/Behavior: check Yes or No. If Yes, indicate frequency: 1 = seldom; 2 = frequent; 3 = always

- | | | |
|--|--|--|
| <input type="checkbox"/> Yes (1, 2, 3) <input type="checkbox"/> No | <input type="checkbox"/> Yes (1, 2, 3) <input type="checkbox"/> No | <input type="checkbox"/> Yes (1, 2, 3) <input type="checkbox"/> No |
| 1. Oriented | 4. Comatose | 7. Hostile |
| 2. Forgetful | 5. Confused | 8. Combative |
| 3. Depressed | 6. Wanders | |

E. Activities of Daily Living: (check appropriate box)

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> 1. Verbal | <input type="checkbox"/> 5. Impaired vision _____ | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> 2. Non-verbal | <input type="checkbox"/> 6. Impaired hearing _____ | <input type="checkbox"/> Hearing Aid |
| <input type="checkbox"/> 3. Bowel Incontinence | <input type="checkbox"/> 7. Bladder Incontinence _____ | |
| <input type="checkbox"/> 4. Dentures _____ | <input type="checkbox"/> 8. Urinary Catheter _____ | |

SELF ASSIST TOTAL

- | | | | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> 10. Eating |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> 11. Bathing |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> 12. Personal |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> 13. Oral Hygiene |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> 14. Ambulation |

F. SPECIAL CARE/PROCEDURES: (check appropriate box: when appropriate give type, frequency, size, stage and site)

- | | |
|--|---|
| <input type="checkbox"/> 1. Ostomy care _____ | <input type="checkbox"/> 7. MRSA _____ |
| <input type="checkbox"/> 2. Glucose Monitoring _____ | <input type="checkbox"/> 8. Diet/Tube Feeding _____ |
| <input type="checkbox"/> 3. Restraints _____ | <input type="checkbox"/> 9. Dialysis _____ |
| <input type="checkbox"/> 4. IV's _____ | <input type="checkbox"/> 10. Respiratory _____ |
| <input type="checkbox"/> 5. Suctioning _____ | <input type="checkbox"/> 11. Decubitus _____ |
| <input type="checkbox"/> 6. Specialized Rehab _____ | <input type="checkbox"/> 12. Other _____ |

G. PHYSICAL EXAMINATION: Height _____ Weight _____ Pulse _____ Resp _____ Temp _____ B/P _____

Lab Results: HCT _____ HGB _____ U/A _____ Radiology _____

General _____ Head and CNS _____

Mouth and EENT _____ Chest _____

Heart and Circulation _____ Abdomen _____

Genitalia _____ Extremities _____

Skin _____ Other _____

H. Physician's Name (Type or Print) _____ PHONE _____

Address: _____

Physician's Signature _____ Date _____