

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 #:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
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 facility care 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"/> NOW <input type="checkbox"/> CC <input type="checkbox"/> Supports <input type="checkbox"/> ROW <input type="checkbox"/> Other: _____			
G. Applicant/Responsible Party Signature: _____		Date: _____	

II. LEVEL OF CARE

The attending physician must designate the required level of care:

- A. ICF/ID - Requires active treatment of developmental disability under supervision of a qualified intellectual / developmental disability professional.
- B. Skilled Care (maximum care required) – Indicate special level, if needed: 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.
- C. Are Home/Community Based Services adequate to meet the needs of this patient? Yes No

D. COMMENTS:

III. MEDICAL INFORMATION

A. Diagnosis: _____ _____		
B. Medications:(Specify dosage, frequency, and route) ALLERGIES		
1. _____	5. _____	9. _____
2. _____	6. _____	10. _____
3. _____	7. _____	11. _____
4. _____	8. _____	12. _____

Recipient's Name: _____

C. Recent Hospitalizations: _____

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

E. Communications: Verbal Non-verbal

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

SELF	ASSIST	TOTAL	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Eating
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Bathing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Personal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Ambulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Transfer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Bowel Incontinence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Bladder Incontinence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Urinary Catheter

<input type="checkbox"/> 9. Impaired vision _____ <input type="checkbox"/> Glasses
<input type="checkbox"/> 10. Impaired hearing _____ <input type="checkbox"/> Hearing Aid
<input type="checkbox"/> 11. Dentures _____

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

<input type="checkbox"/> 1. Ostomy care _____	<input type="checkbox"/> 8. Diet/Tube Feeding _____
<input type="checkbox"/> 2. Glucose Monitoring _____	<input type="checkbox"/> 9. Dialysis _____
<input type="checkbox"/> 3. Restraints _____	<input type="checkbox"/> 10. Respiratory _____
<input type="checkbox"/> 4. IV's _____	<input type="checkbox"/> 11. Wound Care/Decubitus _____
<input type="checkbox"/> 5. Suctioning _____	<input type="checkbox"/> 12. Tracheostomy Care _____
<input type="checkbox"/> 6. Specialized Rehab _____	<input type="checkbox"/> 13. Ventilator Dependent _____
<input type="checkbox"/> 7. MRSA/Infections _____	<input type="checkbox"/> 14. Other _____

H. 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 _____

I. MD Signature is required. A Nurse Practitioner/Physician Assistant signature is allowed for Children's Choice, Supports Waiver, Residential Options Waiver, and New Opportunities Waiver participants. In all cases a supervising physician must be identified.

Physician's Name (print): _____ Phone: _____

Address: _____

Nurse Practitioner/Physician Assistant Name (print): _____

Physician/Nurse Practitioner/Physician Assistant Signature: _____

Date: _____ (Signer please identify profession/credentials)