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:** ☐ M ☐ F		
Medicare #:	**Date of Birth:**	**Relationship:**	**Telephone #:**

D. What are/were the living arrangements: ☐ Own home ☐ Relative's home ☐ 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:
☐ NOW ☐ CC ☐ Supports ☐ ROW ☐ 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

☐Yes (1, 2, 3) ☐No 1. Oriented	☐Yes (1, 2, 3) ☐No 4. Comatose	☐Yes (1, 2, 3) ☐No 7. Hostile
☐Yes (1, 2, 3) ☐No 2. Forgetful	☐Yes (1, 2, 3) ☐No 5. Confused	☐Yes (1, 2, 3) ☐No 8. Combative
☐Yes (1, 2, 3) ☐No 3. Depressed	☐Yes (1, 2, 3) ☐No 6. Wanders	

E. Communications: ☐Verbal ☐Non-verbal

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

SELF	ASSIST	TOTAL	
☐	☐	☐	1. Eating
☐	☐	☐	2. Bathing
☐	☐	☐	3. Personal
☐	☐	☐	4. Ambulation
☐	☐	☐	5. Transfer
☐	☐	☐	6. Bowel Incontinence
☐	☐	☐	7. Bladder Incontinence
☐	☐	☐	8. Urinary Catheter

☐ 9. Impaired vision ________________
☐ Glasses

☐ 10. Impaired hearing________________
☐ Hearing Aid

☐ 11. Dentures ________________

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

☐ 1. Ostomy care________________
☐ 2. Glucose Monitoring________________
☐ 3. Restraints ________________
☐ 4. IV's________________
☐ 5. Suctioning________________
☐ 6. Specialized Rehab________________
☐ 7. MRSA/Infections________________
☐ 8. Diet/Tube Feeding________________
☐ 9. Dialysis________________
☐ 10. Respiratory________________
☐ 11. Wound Care/Decubitus________________
☐ 12. Tracheostomy Care________________
☐ 13. Ventilator Dependent________________
☐ 14. Other________________

H. PHYSICAL EXAMINATION: Height__________Weight________Pulse________Resp________Temp________B/P__________

Lab Results: HCT_________HGB__________U/A___________

General________________

Mouth and EENT________________

Heart and Circulation________________

Genitalia________________

Skin________________

Radiology________________

Head and CNS________________

Chest________________

Abdomen________________

Extremities________________

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. <u>In all cases a supervising physician must be identified.</u>

Physician's Name (print):________________________Phone:________________

Address:________________________________

Nurse Practitioner/Physician Assistant Name (print):________________________

Physician/Nurse Practitioner/Physician Assistant Signature:________________________

Date: ________________ (Signer please identify profession/credentials)