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_____ **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)**