Maryland Medical Assistance Program
Medical Eligibility Review Form PLEASE PRINT OR TYPE

Level of Care/Services Requested (application for rehab hospitals must be accompanied by a plan of care from admitting hospital) (Please check)

☐ NF ☐ Medical Day Care ☐ Rehab Hospital
☐ Chronic Hospital ☐ Other (e.g. Waiver) _____

Application date: _____
Financial Eligibility Date: _____
Social Security #: _____
Medical Assistance #: _____

Part A: Patient Demographics

Patient's Last Name: _____ Patients First Name: _____

Patients Date of Birth: _____Sex_____ Adm. Date_____ Verbal level of care given (LOC):_____

Permanent Address: _____ _____ by_____
Date Utilization Control Agent

_____ Name of Last Provider (Hospital, Long Term Care Facility)

Present location of Patient: (if different from above) Institution: _____

_____ Admission Date: _____

_____ Discharge Date: _____

Patients Representative Name: _____ Relationship to Patient: _____

Representative Phone # _____ Representative Address: _____

Is language a barrier to communication ability? ___ **YES** ___ **NO** _____

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Part B: Physician's Plan of Care (Must be completed by physicians or designee)
Please fill out accurately and completely

Physicians Name: _____ Telephone #: _____ Address: _____

Primary Diagnoses which relate to need for level of care: _____

Secondary/Surgical Diagnoses currently requiring M.D and/or Nursing intervention which relates to level of care:

_____ Date: _____

_____ Date: _____

Other pertinent findings (ex. Signs and symptoms, complications, lab results, etc… _____

_____

_____

_____

Is patient free from infection TB? ___ **YES** ___ **NO** Determined by: ___ Chest X-Ray ___ PPD Date: _____

T _____ P _____ R _____ B/P _____ HT _____ WT _____

Have any of the above vital signs undergone a significant change? ___ **YES** ___ **NO** If yes explain: _____

_____

Diet (Include supplements and tubefeeding solution) _____

Patients Name: _____

Medication which will be Continued:

Medication	Dosage	Frequency	Route	If PRN, avg frequency actually given

Treatment which will Be Continued: Description Frequency Duration if Temporary

___ Ventilator: _____

___ 0_2 (as well as sats and frequency): _____

___ Monitor (apnea/bradycardia (A/B), other: _____

___Suctioning: _____

___ Trach Care: _____

___ IV Line/fluids (indicate central or peripheral): _____

___ Tube feeding (specify type of tube): _____

___ Colostomy/ileostomy care: _____

___ Catheter/continence device (specify type): _____

___ Frequent labs related to nutrition/needs (describe): _____

___ Decubitus (include size, location, stage, drainage, and signs of infection, also Tx regimen): _____

_____

___ Other (specify): _____

_____

Have any medications or treatments recently been implemented, discontinued, and/or otherwise changed? Explain:

_____

_____

Impairments/devices (check all that apply) ___Speech ___ Sight ___Hearing ___ Other (specify) _____

___ Devices/Adaptive Equipment _____

Active Therapy	Plan	Frequency	Est. Duration	Goal
Physical Therapy				
Occupational Therapy				
Speech Therapy				
Respiratory				
Others				

Patients Name: _____

Rehabilitation Potential: _____

Discharge Plan: _____

*If requesting a level of care for rehab hospital, please answer the following questions:

1. Preexisting condition related to current physical, behavioral and mental functions and deficits: _____

_____

2. Reason for out-of-state placement (if applicable): _____

Is Patient Comatose? ___ YES ___ NO if yes skip parts C through E and go directly to part F.

PLEASE NOTE: For other adults applicants, complete parts C and D, skip E. For applicants under age 21, skip Parts C and D, complete E.

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Part C: Functional Status (Use one of the following codes)

(if assistive device (e.g., Wheelchair, walker) used, note functional ability while using device)

0. Little or no difficulty (completely independent or setup only is needed
1. Supervision/Verbal cuing
2. Limited physical assistance by caregiver
3. Extensive physical assistance by caregiver
4. Total dependence on others

___ Locomotion (if using adaptive/assistive device,

Specify type: _____

___ Transfer bed/chair

___ Reposition/Bed Mobility

___ Dressing

___ Bathing

___ Eating

Appetite (check one): ___Good ___Fair ___ Poor

Other Functional limitations (describe) _____

Incontinence management (Circle applicable choices in each category) (Note status with toileting program and/or continence device, if applicable)

Bladder	Bowel	
0	0	Complete control-or infrequent stress incontinence
1	1	Usually continent-accidents once a week or less
2	2	Occasionally incontinent-accidents 2+ weekly, but not daily
3	3	Frequently incontinent- accidents daily but some control present
4	4	Incontinent- Multiple daily accidents

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Part D: Cognitive/Behavioral Status

1. Memory/orientation Y=yes N=no

Yes	No	
___	___	Can recall after 5 minutes
___	___	Knows current season
___	___	Knows own name
___	___	Can recall long past events
___	___	Knows present location
___	___	Knows family/caretaker

2. Cognitive skills for daily life decision making and safety (check one)

___ Independent decisions consistent and reasonable

___ Modified/some difficulty in new situations only

___ Moderately impaired/decisions requires cues/supervision

___ Severely impaired/rarely or never makes decisions

3. Communication	0-Always,	1-Usually,	2-Sometimes,	3-Rarely
Ability to understand others	_____	_____	_____	_____
Ability to make self understood	_____	_____	_____	_____
Ability to follow simple commands	_____	_____	_____	_____

Patients Name: _____

4. Behavior issues (enter one code from A and B in the appropriate column)

A. Frequency
1= Occasionally
2= Often, but not daily
3= Daily

B. Easily Altered
1= Yes
2= No

Description of Problem Behaviors	A	B

5. Most recent mini-mental score _____ Date: _____

Previous mini-mental score (if available) _____ Date: _____

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Part E: Functional/Cognitive Status – Pediatric

	Age Appropriate	Functioning level	Adaptive Equipment	
Cognition			Wheelchair	
Social/Emotional			Splints/Braces	
Behavior			Side Lyer	
Communications			Walker	
Gross Motor Abilities			Adaptive Seating	
Fine Motor Abilities			Communication devices	
Feeding			Other	
Toileting				
Self Care				

Part F: Physician's Certification for Level of Care

This patient is certified as in need of the following services (check one):

☐ NF ☐ Medical Day Care ☐ Rehab Hospital ☐ Chronic Hospital ☐ Other (e.g. Waiver)

Other information pertinent to need for Long Term Care: _____

Physicians Signature: _____ Date: _____

Other than physician completing form: _____

Signature Title Phone Date

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This area is for Agent Determination Only. Do Not write in this area.

Renewal

___ Medical Eligibility Established MD Advisor ___

___ Medical Eligibility Denied

Effective Date: _____

Type of Service: _____

Certificate Period: From: _____ To: _____

Agent Signature: _____

Date: _____

___ Medical Eligibility Established MD Advisor ___

___ Medical Eligibility Denied

Effective Date: _____

Type of Service: _____

Certificate Period: From: _____ To: _____

Agent Signature: _____

Date: _____