Maryland Medical Assistance
Medical Eligibility Review Form #3871B

Part A – Service Requested

1. Requested Eligibility Date: _____
2. Admission Date _____
3. Facility MA Provider #: _____

4. Check Service Type Below:

- ☐ Nursing Facility
- ☐ Medical Day Care Waiver
- ☐ Waiver for Older Adults
- ☐ Living at Home Waiver
- ☐ PACE
- ☐ Model Waiver vent only dependent (all other MW use 3871)
- ☐ Chronic Hospital vent dependent only (all other CH use 3871)

5. Check Type of Request

- ☐ Initial
- ☐ Conversion to MA (NF)
- ☐ Medicare ended (NF)
- ☐ MCO disenrollment (NF)
- ☐ Readmission – bed reservation exp. (NF)
- ☐ Transfer new provider (NF)
- ☐ Update expired LOC
- ☐ Corrected Date
- ☐ Significant change from previously denied request
- ☐ Recertification (Waivers/PACE only)
- ☐ Advisory (please include payment)

Part B – Demographics

1. Client Name: Last _____First _____ MI _____ Sex: M ☐ F ☐

SS# _____- ____- _____ MA # _____ DOB _____

2. Current Address (check one): ☐ Facility ☐ Home

Address 1 _____

Address 2 _____

City _____ State _____ ZIP _____ Phone _____

If placed in facility, name of facility _____

If in acute hospital, name of hospital_____

3. Next of Kin/ Representative

Last name _____ First Name _____ MI _____

Address 1 _____

Address 2 _____

City _____ State _____ ZIP _____ Phone _____

4. Attending Physician

Last name _____ First Name _____ MI _____

Address 1 _____

Address 2 _____

City _____ State _____ ZIP _____ Phone _____

Applicant Name _____

Part C – MR/MI Please Complete the Following on All Individuals:

Review Item	Answer Y	Answer N
1. Is there a diagnosis or presenting evidence of mental retardation/related condition, or has the client received MR services within the past two years?	☐	☐
2. Is there any presenting evidence of mental illness? Please note: Dementia/Alzheimer's is not considered a mental illness.	☐	☐
a. If yes, check all that apply. ☐ Schizophrenia ☐ Personality disorder ☐ Somatoform disorder ☐ Panic or severe anxiety disorder ☐ Mood disorder ☐ Paranoia ☐ Other psychotic or mental disorder leading to chronic disability		
3. Has the client received inpatient services for mental illness within the past two years?	☐	☐
4. Is the client on any medication for the treatment of a major mental illness or psychiatric diagnosis?	☐	☐
a. If yes, is the mental illness or psychiatric diagnosis controlled with medication?	☐	☐
5. Is the client a danger to self or others?	☐	☐

Part D – Diagnoses

Primary diagnosis related to the need for requested level of care	ICD Code		Description	
Other active diagnoses related to the need for requested level of care	Descriptions			

Part E – Skilled Services:

Requires a physician's order. Requires the skills of technical or professional personnel such as a registered nurse, licensed practical nurse, respiratory therapist, physical therapist, and/or occupational therapist. The service must be inherently complex such that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. Items listed under Rehabilitation and Extensive Services may overlap.

Table I. Extensive Services (serious/unstable medical condition and need for service)

Review Item (Please indicate the number of days per week each service is required)	# of days service is required/wk. (0-7)
1. Tracheotomy Care: All or part of the day	
2. Suctioning: Not including routine oral-pharyngeal suctioning, at least once a day	
3. IV Therapy: Peripheral or central (not including self-administration)	
4. IM/SC Injections: At least once a day (not including self-administration)	
5. Pressure Ulcer Care: Stage 3 or 4 and one or more skin treatments (including pressure-relieving bed, nutrition or hydration intervention, application of dressing and/or medications)	
6. Wound Care: Surgical wounds or open lesions with one or more skin treatments per day (e.g., application of a dressing and/or medications daily)	
7. Tube Feedings: 51% or more of total calories or 500 cc or more per day fluid intake via tube	
8. Ventilator Care: Individual would be on a ventilator all or part of the day	
9. Complex respiratory services: Excluding aerosol therapy, spirometry, postural drainage or routine continuous O2 usage	
10. Parenteral Feeding or TPN: Necessary for providing main source of nutrition.	
11. Catheter Care: Not routine foley	
12. Ostomy Care: New	

13. Monitor Machine: For example, apnea or bradycardia	
14. Formal Teaching/Training Program: Teach client or caregiver how to manage the treatment regime or perform self care or treatment skills for recently diagnosed conditions (**must be ordered by a physician)**	

Table II. Rehabilitation (PT/OT/Speech Therapy services) Must be current ongoing treatment.

Review Item (Please indicate the number of days per week each service is required.)	No. of days service is required/wk. (0-7)
15. Extensive Training for ADLs. (restoration, not maintenance), including walking, transferring, swallowing, eating, dressing and grooming.	
16. Amputation/Prosthesis Care Training: For new amputation.	
17. Communication Training: For new diagnosis affecting ability to communicate.	
18. Bowel and/or Bladder Retraining Program: Not including routine toileting schedule.	

Part F – Functional Assessment

Review Item	**Answer**	
Cognitive Status (Please answer Yes or No for EACH item.)	**Y**	**N**
1. Orientation to Person: Client is able to state his/her name.	☐	☐
2. Medication Management: Able to administer the correct medication in the correct dosage, at the correct frequency without the assistance or supervision of another person.	☐	☐
3. Telephone Utilization: Able to acquire telephone numbers, place calls, and receive calls without the assistance or supervision of another person.	☐	☐
4. Money Management: Can manage banking activity, bill paying, writing checks, handling cash transactions, and making change without the assistance or supervision of another person.	☐	☐
5. Housekeeping: Can perform the minimum of washing dishes, making bed, dusting, and laundry, straightening up without the assistance or supervision of another person.	☐	☐
6. Brief Interview for Mental Status (BIMS): Was the examiner able to administer the complete interview? If yes, indicate the final score. If no, indicate reason. (Examination should be administered in a language in which the client is fluent.) If yes, Score: _____ If No, check one of the following: ☐ Hearing Loss ☐ Applicant is rarely/never understood ☐ Language Barrier ☐ Refused ☐ Other (specify) _____	☐	☐

Behavior (Please answer Yes or No for EACH item.)	**Answer**	
	Y	**N**
7. Wanders (several times a day): Moves with no rational purpose or orientation, seemingly oblivious to needs or safety.	☐	☐
8. Hallucinations or Delusions (at least weekly): Seeing or hearing nonexistent objects or people, or a persistent false psychotic belief regarding the self, people, or objects outside of self.	☐	☐
9. Aggressive/abusive behavior (several times a week): Physical and verbal attacks on others including but not limited to threatening others, hitting, shoving , scratching, punching, pushing, biting, pulling hair or destroying property.	☐	☐
10. Disruptive/socially inappropriate behavior (several times a week): Interferes with activities of others or own activities through behaviors including but not limited to making disruptive sounds, self-abusive acts, inappropriate sexual behavior, disrobing in public, smearing/throwing food/feces, hoarding, rummaging through other's belongings, constantly demanding attention, urinating in inappropriate places.	☐	☐
11. Self-injurious behavior (several times a month): Repeated behaviors that cause injury to self, biting, scratching, picking behaviors, putting inappropriate object into any body cavity, (including ear, mouth, or nose), head slapping or banging.	☐	☐

Applicant Name _____

Communication (Please answer Yes or No for EACH item.)	**Answer** Y	N
12. Hearing Impaired even with use of hearing aid: Difficulty hearing when not in quiet setting, understands conversations only when face to face (lip-reading), can hear only very loud voice or totally deaf.	☐	☐
13. Vision Impaired even with correction: Difficulty with focus at close range, field of vision is severely limited (tunnel vision or central vision loss), only sees light, motion, colors or shapes, or is totally blind.	☐	☐
14. Self Expression: Unable to express information and make self understood using any means (with the exception of language barrier).	☐	☐

Review Item	
FUNCTIONAL STATUS: Score as Follows **0 = Independent:** No assistance or oversight required **1 = Supervision:** Verbal cueing, oversight, encouragement **2 = Limited assistance:** Requires hands on physical assistance **3 = Extensive assistance:** Requires full performance (physical assistance and verbal cueing) by another for more than half of the activity. **4 = Total care:** Full activity done by another	**Score Each Item (0-4)**
15. Mobility: Purposeful mobility with or without assistive devices.	
16. Transferring: The act of getting in and out of bed, chair, or wheelchair. Also, transferring to and from toileting, tub and/or shower.	
17. Bathing (or showering): Running the water, washing and drying all parts of the body, including hair and face.	
18. Dressing: The act of laying out clothes, putting on and removing clothing, fastening of clothing and footwear, includes prostheses, orthotics, belts, pullovers.	
19. Eating: The process of putting foods and fluids into the digestive system (including tube feeding).	
20. Toileting: Ability to care for body functions involving bowel and bladder activity, adjusting clothes, wiping, flushing of waste, use of bedpan or urinal, and management of any special devices (ostomy or catheter). This does not include transferring (See transferring item 16 above).	
CONTINENCE STATUS: Score as Follows **0 = Independent:** Totally continent, can request assistance in advance of need, accidents only once or twice a week or is able to completely care for ostomy. **1 = Dependent:** Totally incontinent, accidents three or more times a week, unable to request assistance in advance of need, continence maintained on toileting schedule, indwelling, suprapubic or Texas catheter in use or unable to care for own ostomy.	**Score Each Item (0-1)**
21. Bladder Continence: Ability to voluntarily control the release of urine from the bladder	
22. Bowel Continence: Ability to voluntarily control the discharge of stool from the bowel.	

Part G – Certification

1. Signature of Person Completing Form: _____ Date_____

   Printed Name_____

I certify to the best of my knowledge the information on the form is correct.

2. Signature of Health Care Professional: _____ Date_____

   Printed Name_____