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)

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

☐ Chronic Hospital* ☐ Model Waiver*

(If patient is on a ventilator, please use the DHMH 3871B with the Ventilator Questionnaire)

Part A: Patient Demographics

Patient's Last Name: _____ Patient's First Name: _____
Patients Date of Birth: _____ Sex: ____Adm. Date: _____
Permanent Address: _____

_____ Name of Last Provider (Hospital, Long Term Care Facility)
Present location of Patient: (if different from above) Institution: _____
_____ Admission Date: _____
_____ Discharge Date: _____
Patient's 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 tube feeding solution) _____

Patient's Name: _____

Medication which will be continued:

Medication	Dosage	Frequency	Route	If PRN, avg frequency

Treatment which will be continued: Description Frequency Duration if Temporary

____ Ventilator: _____

____ O_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				

Patient's Name: 5674

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	____	____	____	____

Patient's 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 _____ 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):

☑ Chronic Hospital ☑ Model Waiver

Other information pertinent to need for Long Term Care: _____

Physician's 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: _____

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