LOUISIANA DEPARTMENT OF HEALTH
Office for Citizens with Developmental Disabilities

REQUEST FOR MEDICAL ELIGIBILITY DETERMINATION

I. APPLICANT INFORMATION

A. Applicant'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 or Nurse Practitioner must designate the required level of care:

A. ☐ **ICF/IID - 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 applicant? ☐ **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.** _____

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Replaces all prior issues

Applicant'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 or Nurse Practitioner signature is required. MD signature may be delegated to a Physician Assistant. In this case, a supervising physician must be identified.

Physician or Nurse Practitioner's Name: (print):_____ **Phone:**_____

Address:_____

Physician Assistant Name (print):_____

Physician/Nurse Practitioner/Physician Assistant Signature:_____

Date: _____ **(Signer please identify profession/credentials)**

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