

MED REFERRAL FORM
Medical Eligibility Determination



1.	REFERRAL DATE	Month Day Year			
2.	APPLICANT NAME	First: _____ (MI) _____ Last: _____			
3.	BIRTH DATE	Month Day Year			
4.	GENDER	1. Male 2. Female		<input type="checkbox"/>	
5.	MARITAL STATUS	1. Never Married 3. Widowed 5. Divorced 2. Married 4. Separated		<input type="checkbox"/>	
6.	CITIZENSHIP	1. US Citizen 2. Legal Alien 3. Other		<input type="checkbox"/>	
7.	PRIMARY LANG	0. English 2. Spanish 1. French 3. Other		<input type="checkbox"/>	
7A	INTERPRETER REQUIRED	0. No 1. Yes 2. unknown		<input type="checkbox"/>	
8.	Race/Ethnicity (Optional)	1. Am Indian/Alaskan 2. Asian 3. Black 4. Hispanic/Latino 5. White 6. Other _____ 7. Hawaii/Pacific <input type="checkbox"/>			
9.	Residence Address	Street _____ City/Town _____ Cty _____ ST _____ Zip _____ Ph. _____			
10.	MAINECARE NO. If Applicable				
11.	Medicare No.				
12.	SSN#				
13.	INCOME SUMMARY	Source	Recipient	Amount	Frequency
		<input type="checkbox"/> Not Known			
14.	LEGAL GUARDIAN	Does the applicant have a legal guardian? 0. No 1. Yes 2. Not Known <input type="checkbox"/>			
15.	REFERRAL INFORMATION	Is applicant aware of referral? 0. No 1. Yes <input type="checkbox"/>			
16.	VISUAL/ HEARING	a. Visual Impairment 0. No 1. Yes <input type="checkbox"/>			
		b. Hearing Loss 0. No 1. Yes <input type="checkbox"/>			
17.	COGNITIVE/ BEHAVIOR	a. Cognitive Impairment 0. No 1. Yes <input type="checkbox"/>			
		b. Behavioral Probs 0. No 1. Yes <input type="checkbox"/>			
18.	ADVANCED DIRECTIVES (For only those items with supporting documentation)	(Click all that apply)			
		a. Living will	a.	f. Feeding restrictions	f.
		b. Do not Resuscitate	B	g. Medication restrictions	g.
		c. Do not hospitalize	C.	h. other	h.
		d. Organ Donation	d.	i. None of the Above	i.
		e. Autopsy Request	e.		
19.	CURRENT COMMUNITY CARE PLAN n/a				
	PROVIDER	SERVICE CATEGORY SEE CODING SHEET	FREQUENCY # HOURS/VISITS PER MONTH	DURATION START DATE END DATE	FUNDING SOURCE

20.	REFERRAL SOURCE	1. Nursing Facility 7. Provider Agency 2. Consumer 8. Community Agency 3. Family Member 9. Advocacy Agency 4. Hospital 10. Physician 5. OFI 11. Other State Agency 6. Residential Care 12. Other <input type="checkbox"/>			
21.	LOCATION AT TIME OF ASSESSMENT	1. Hospital Campus _____ Room# _____ 2. Home/Apt 3. Independent Housing 4. Res Care Facility 5. Nursing Home Campus _____ Room# _____ 6. Assisted Living 7. Adult Family Care Home 8. Adult Foster Home 9. Other <input type="checkbox"/>			
22.	PROVIDER REFERRAL	a. Referring Provider/Facility Name <input type="checkbox"/> N/A b. Provider Contact Name _____ c. Telephone No. _____ d. Fax No. _____			
23.	PERSONAL/ OTHER/ REFERRAL	a. Referred By: _____ <input type="checkbox"/> N/A b. Contact Name: _____ c. Telephone No. _____			
24.	ASSESSMENT TRIGGER	1. Service Need 4. Financial Change 2. Reassessment Due <input type="checkbox"/>			
25.	ASSESSMENT TYPE	1. Initial 2. Reassessment Due Date: _____ <input type="checkbox"/>			
26.	PROGRAM ASSESSMENT REQUESTED	1. Long Term Care Advisory 20. Cont. Stay Review 4. MaineCare Day Health I, II, III 21. Ext Ordinary Circum to NF 5. Consumer Directed PA I, II, III 23. PDN IV (FPSO) 6. Home Based Care (SCA only) 25. TBI-Brain Injury NF 8. Elderly and Adults HCBS 29. Consumer Directed HBC (SCA only) 10. PDN Level I, II, III, VIII 30. ALF (HBC V, PDN IX only) 11. Adult Family Care Home 31. Residential Care 12. PDN V 32. MFP-Homeward Bound 13. NF Assessment 33. ORC-Other Related Conditions 14. 20 Day Medicare/MaineCare 34. Acquired Brain Injury Waiver 15. Medicare to MaineCare 16. 20-day Co-pay to NF 17. 30 Day Community MaineCare 18. Adv to MaineCare update 19. Adv. Medicare to Pvt Pay			
27.	NF/HOSPITAL/ HOME HEALTH DATES	a. Acute care denial date: _____ <input type="checkbox"/> N/A b. First non SNF date: _____ <input type="checkbox"/> N/A c. 20th day date: _____ <input type="checkbox"/> N/A d. Last day pvt. pay: _____ <input type="checkbox"/> N/A e. Late notification date: 0. No 1. Yes f. Bed hold expire: 0. No 1. Yes g. Admission date: _____ <input type="checkbox"/> N/A h Discharge date: _____ <input type="checkbox"/> N/A i. Home health end date: _____ <input type="checkbox"/> N/A			
28.	PHYSICIAN	Name: _____ Address: _____ Telephone: _____			
29.	EMERGENCY OR FAMILY CONTACT	Name: _____ Address: _____ Relationship: _____ Telephone: _____ Legal Guardian Yes No POA Medical Yes No POA Financial Yes No			

Comments: