

MEDICAL EVALUATION

 NEW UPDATED

1. MA RECIPIENT NUMBER	2. NAME OF APPLICANT (Last, first, middle initial)	3. SOCIAL SECURITY NO.	4. BIRTHDATE	5. AGE	6. SEX
7. ATTENDING PHYSICIAN		8. PHYSICIAN LICENSE NUMBER			
9. EVALUATION AT (Description and code) 01 Hospital 02 NF 03 Personal Care/Dom Care 04 Own House/Apartment 05 Other (Specify) _____		10. For the purpose of determining my need for TITLE XIX INPATIENT CARE, Home and Community Based Services, and if applicable, my need for a shelter deduction, I authorize the release of any medical information by the physician to the County Assistance Office, State Department of Public Welfare or its agents. _____ SIGNATURE - APPLICANT OR PERSON ACTING FOR APPLICANT _____ DATE			

11. HEIGHT	WEIGHT	BLOOD PRESSURE	TEMPERATURE	PULSE RATE	CARDIAC RHYTHM
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12. MEDICAL SUMMARY

13. IN EVENT OF AN EMERGENCY THE PATIENT CAN VACATE THE BUILDING <input type="checkbox"/> 1. Independently <input type="checkbox"/> 2. With Minimal Assistance <input type="checkbox"/> 3. With Total Assistance	14. PATIENT IS CAPABLE OF ADMINISTERING HIS/HER OWN MEDICATIONS <input type="checkbox"/> 1. Self <input type="checkbox"/> 2. Under Supervision <input type="checkbox"/> 3. No
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15. ICD-9-CM DIAGNOSTIC CODES																									
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16. PROFESSIONAL AND TECHNICAL CARE NEEDED - CHECK ✓ EACH CATEGORY THAT IS APPLICABLE					
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Inhalation Therapy	<input type="checkbox"/> Special Dressings	<input type="checkbox"/> Irrigations
<input type="checkbox"/> Special Skin Care	<input type="checkbox"/> Parenteral Fluids	<input type="checkbox"/> Suctioning	<input type="checkbox"/> Other (Specify) _____		

17. PHYSICIAN ORDERS
Medications _____
Treatment _____
Rehabilitative and Restorative Services _____
Therapies _____
Diet _____
Activities _____
Social Services _____
Special Procedures for Health and Safety or to Meet Objectives _____

18. PROGNOSIS - CHECK ✓ ONLY ONE <input type="checkbox"/> 1. Stable <input type="checkbox"/> 2. Improving <input type="checkbox"/> 3. Deteriorating	19. REHABILITATION POTENTIAL - CHECK ✓ ONLY ONE <input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Limited <input type="checkbox"/> 3. Poor
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20A. PHYSICIAN'S RECOMMENDATION	To the best of my knowledge, the patient's medical condition and related needs are essentially as indicated above. I recommend that the services and care to meet these needs can be provided at the level of care indicated - check ✓ only one				
<input type="checkbox"/> Nursing Facility Clinically Eligible Services to be provided at home or in a nursing facility	<input type="checkbox"/> Personal Care Home Services provided in a Personal Care Home	<input type="checkbox"/> ICF/MR Care Services to be provided at home or in an Intermediate care facility for the mentally retarded	<input type="checkbox"/> ICF/ORC Care Services to be provided at home or in an Intermediate care facility for consumers with ORCs	<input type="checkbox"/> Inpatient Psychiatric Care	<input type="checkbox"/> Other (Please Specify) _____

20B. COMPLETE ONLY IF CONSUMER IS NURSING FACILITY CLINICALLY ELIGIBLE AND WILL BE SERVED IN A NURSING FACILITY. ON THE BASIS OF PRESENT MEDICAL FINDINGS THE PATIENT MAY EVENTUALLY RETURN HOME OR BE DISCHARGED.	<input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, Check ✓ Only One <input type="checkbox"/> 1. Within 180 days <input type="checkbox"/> 2. Over 180 days
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20C. PHYSICIAN'S SIGNATURE
_____ PHYSICIAN (PRINTED NAME) _____ TELEPHONE _____ PHYSICIAN SIGNATURE _____ DATE

FOR DEPARTMENT USE Medical and other professional personnel of the Medicaid agency or its designee MUST evaluate each applicant's or recipient's need for admission by reviewing and assessing the evaluations required by regulations.	
21A. MEDICALLY ELIGIBLE <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Medically Appropriate for Waiver Services	21B. Length of Stay <input type="checkbox"/> Within 180 days <input type="checkbox"/> Over 180 days
22. Comments. Attach a separate sheet if additional comments are necessary. _____ REVIEWER'S SIGNATURE AND TITLE _____ DATE	