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 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. ______________________________

OCDD Form 90-L (OCDD-PF-22-004)
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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________

General________________

Mouth and EENT________________

Heart and Circulation________________

Genitalia________________

Skin________________

Radiology________________

Head and CNS________________

Chest________________

Abdomen________________

Extremities________________

Other________________

I. MD Signature is required. MD signature may be delegated to a Nurse Practitioner or Physician Assistant. <u>In all cases a supervising physician must be identified.</u>

Physician's Name (print):________________________________Phone:________________

Address:____

Nurse Practitioner/Physician Assistant Name (print):________________________________

Physician/Nurse Practitioner/Physician Assistant Signature:________________________________

Date: ________________ (Signer please identify profession/credentials)