MEDICAL ELIGIBILITY DETERMINATION (MED)

Background Information

Assessment Start Date: ☐☐–☐☐–☐☐☐☐ (Month Day Year) Provider-Assessor # ☐☐☐☐☐☐☐☐☐–☐☐☐

Name of Person Coordinating Assessment _____ Title _____

Agency/Organization _____ Phone Number _____

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1.	APPLICANT NAME	First: _____ (MI) _____ Last: _____
2.	ADDRESS	Street _____ City/Town _____ Cnty _____ State _____ Zip _____ Phone (___) _____
3.	SOCIAL SECURITY NO.	☐☐☐–☐☐–☐☐☐☐
4.	MAINECARE NO. *(if applicable)*	☐☐☐☐☐☐☐☐☐
5.	MEDICARE NO.	☐☐☐☐☐☐☐☐☐☐☐
6A.	ASSESSMENT TRIGGER	1. Service Need 3. Significant Medical Change 2. Reassessment due 4. Financial Change ☐
6B.	PROGRAM ASSESSMENT REQUESTED *(Choose only one.)*	1. Long Term Care Advisory 2. Adult Day Services 3. OES Homemaker 4. MaineCare Day Health I,II,III 5. Consumer Directed PA I,II,III 6. Home Based Care 7. Phys. Dis. HCB 8. Elderly HCB 9. Adults w/ Disability HCB 10. PDN - Level I, II, III, VIII 11. Adult Family Care Home 12. Level V - Extended PDN 13. NF Assessment 14. 20-day Medicare/MaineCare 15. Medicare to MaineCare 16. 20-day copay to NF MaineCare 17. 30-day Community MaineCare NF 18. Advisory to MaineCare Update 19. Adv. Medicare to Private Pay NF 20. Continuing Stay Review 21. Extraordinary Circumstances to NF 22. Katie Beckett 23. NF PDN - Level IV 24. Independent Housing 25. BI - Brain Injury NF 26. MaineCare Home Health 27. PDN Medication - Level VI 28. PDN Venipuncture Only - Level VII 29. Consumer Directed HBC 30. Assisted Living 31. Residential Care ☐
7.	GENDER	1. Male 2. Female ☐
8.	RACE/ ETHNICITY *(Optional)*	1-Am Indian/Alaskan 2-Asian 3-Black 4-Hispanic/Latino 5-White 6-Other _____ 7-Hawaiian/Pacific Isl ☐
9.	BIRTH DATE	☐☐–☐☐–☐☐☐☐ (Month Day Year)
10A.	MARITAL STATUS	1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated ☐
10B.	CITIZENSHIP	1. U.S. Citizen 2. Legal alien 3. Other ☐
11.	PRIMARY LANGUAGE	0. English 2. Spanish 4. to 87. - See instructions 1. French 3. Other _____ Interpreter Req ☐ ☐
12.	CURRENT INCOME SOURCE FOR APPLICANT & HOUSEHOLD	*(Check all that apply.)* App. Hshld. a/b. Social Security a b c/d. Private Pension c d e/f. VA Benefits e f g/h. SSI g h i/j. Other i j k/l. Assets >$2000.00 k l

13.	CURRENT OR POTENTIAL PAYMENT SOURCE *(Code a response in each box.)*	0. Not eligible 1. Eligible 2. Eligibility pending (application filed) 3. Eligibility anticipated (application not yet filed) 4. Unknown a. Community MaineCare (Routine home health, PDN) a b. HCB - Elderly, AD b c. HCB - Phys. Dis. c d. NF MaineCare d e. Medicare Part A e f. Medicare Part B f g. Champus g h. VA h i. Title XX i j. Other j
14.	LOCATION AT TIME OF ASSESSMENT & USUAL RESIDENCE	1. Hospital 2. Home/apartment 3. Independent Housing 4. Residential Care Facility 5. Nursing Home 6. Assisted Living Unit 7. Adult Family Care Home 8. Adult Foster Home 9. Other _____ A. Location at time of assessment ☐ B. Usual place of residence ☐
15.	USUAL LIVING ARRANGEMENT	Lives with: *(Check all that apply.)* a. Alone a b. With spouse b c. With children c d. With other residents d e. With parents e f. With friend f g. With sibling g h. Sig. other h i. Other _____ i
16.	NO. IN HOUSEHOLD *(Incl. applicant)*	*Other than in institution/residential care facilities* ☐☐
17.	RESPONSI-BILITY/LEGAL GUARDIAN *(For only those items with supporting documentation)*	*(Check all that apply.)* a. Legal guardian a b. Other legal oversight b c. Durable power attorney/ health care proxy c d. Family member responsible d e. Applicant responsible e f. Other f g. Unknown g
18.	ADVANCED DIRECTIVES *(For only those items with supporting documentation)*	*(Check all that apply.)* a. Living will a b. Do not resuscitate b c. Do not hospitalize c d. Organ donation d e. Autopsy request e f. Feeding restrictions f g. Medication restrictions g h. Other _____ h i. NONE OF ABOVE i

19. CONTACTS

A. Name _____
Address _____
Relationship _____
Telephone _____ Legal Guardian ☐ Yes ☐ No

B. Name _____
Address _____
Relationship _____
Telephone _____ Legal Guardian ☐ Yes ☐ No

20. REFERRING PHYSICIAN _____
Address _____
Telephone _____

CONTINUING PHYSICIAN _____
Address _____
Telephone _____