Medical Evaluation of Applicant For Level of Care For Admission To A Skilled Nursing Facility, Assisted Living or Community Based Services

Instructions To The Examining Provider

As the examining provider (MD, DO, RNP, PA), you will be assessing the patient's Functional Activities and Medical Diagnosis/Treatment using the following forms. Note: it must represent the patient's CURRENT condition. Please include dates.

The patient listed below has requested that the Office of Health and Human Services (OHHS) obtain this medical evaluation form from you as a basis for application. You are requested to complete this form in detail so that the Office of Medical Review (OMR) within OHHS can determine the level of care.

Code Key

Key indicates the patient's ability to care for self during a 24 hour period (over the last seven days). (for use on page 3)

0 = Independent – No help or oversight – **OR** – help/oversight provided only 1 or 2 times during the last seven days

1 = Supervision – Oversight, encouragement or cueing provided 3 or more times – **OR** – Supervision (3 or more times) plus limited physical assistance provided only 1 or 2 times during the last seven days.

2 = Limited Assistance – Individual highly involved in activity, received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 3 or more times **– OR –** Limited assistance (3 or more times) plus extensive assistance provided only 1 or 2 times in the last seven days.

3 = Extensive Assistance – While individual performed part of activity, weight-bearing support or full caregiver performance 3 or more times over part (but not all) of the last seven days.

4 = Total Dependence – Full caregiver performance of the activity each time the activity occurred during the entire seven-day period. There is complete non-participation by the individual in all aspects of the ADL definition task. If the caregiver performed an activity for the individual during the entire observation period, but the individual performed part of an activity him/herself, it would **NOT** be coded as a "4" Total Dependence.

5 = Activity did not occur

Provider Medical Statement

Date: _____

Applicant Name: _____ **Date of Birth:** _____

SS# or MID: _____ **Gender:** ☐ **Male** ☐ **Female**

Address: _____ **Apt./Floor:** _____

City/Town: _____ **State:** _____ **Zip Code:** _____

Current Living Arrangement: ☐ **Lives Alone** ☐ **Lives with others** ☐ **Other:** _____

Name of Facility: _____ **Date Admitted:** _____

DIAGNOSIS: Medical & Behavioral (including severity of condition) *NO DIAGNOSIS CODES		
PRIMARY DX (onset)	**OTHER DX (onset)**	**SURGERY/INFECTIONS (include dates)**

Prognosis of Rehabilitation Potential: _____

Permanent Disability: ☐ **Yes** ☐ **No**

MEDICATIONS		
DOSE	**FREQUENCY**	**ROUTE**

PRESENT TREATMENTS & FREQUENCY
Provider Orders (Include specific orders for Diet, PT/OT/ST, Oxygen)

Therapies:

PT _____ **x's/wk for** _____ **/wk's**

OT _____ **x's/wk for** _____ **/wk's**

ST _____ **x's/wk for** _____ **/wk's**

Respiratory Therapy _____

Chemotherapy/Radiation ☐

Dialysis ☐

Diet _____

Tube Feeding _____

Oxygen liters _____ **prn** ☐ **cont.** ☐

Wound Care (sites) _____ **Size** _____

Pressure ulcers # _____ **Location** _____

Stage _____ **Size** _____ **cm**

Bladder & Bowel Training ☐

Incontinence:

Bladder ☐ **Yes** ☐ **No** **Frequency** _____

Bowel ☐ **Yes** ☐ **No** **Frequency** _____

Foley ☐

Colostomy ☐

Urostomy ☐

Other _____

Current Functional Activities

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Please refer to the Code Key (on page 1) to indicate the level of assistance required.
Code Key: 0 = Independent 1 = Supervision 2 = Limited Assistance 3 = Extensive Assistance
4 = Total Dependence 5 = Activity did not occur

_____ **Transfer**
_____ **Ambulation** _____ **Cane** _____ **Walker** _____ **Wheelchair**
_____ _____ **Bed to Chair** _____ **Bedridden**
_____ **Bed Mobility**
_____ **Dressing**
_____ **Bathing**
_____ **Toileting**
_____ **Eating**
_____ **Personal Hygiene**
_____ **Medication Mgmt**
_____ **Housekeeping** _____ **Meal Prep** _____ **Shopping** _____ **Laundry**

Can the patient go out unaccompanied? ☐ **Yes** ☐ **No**
Can the patient utilize public transportation independently? ☐ **Yes** ☐ **No**

PAIN SCALE

1 2 3 4 5 6 7 8 9 10 **Location:** _____ **Frequency** _____
(none) (moderate) (severe)

Does pain interfere with individual's activity or movement? ☐ **Yes** ☐ **No**
Is pain relieved by medication/treatment? ☐ **Yes** ☐ **No**

COGNITIVE STATUS

Is the patient impaired? ☐ **Yes** ☐ **No** **MMSE Score** ____ **BIMS Score** _____ **Date** _____

Cognitive Skills for Daily Decision Making (please check one)

☐ **Independent:** Decisions consistent/reasonable
☐ **Modified Independence:** Some difficulty in new situations only
☐ **Moderately Impaired:** Decision poor/cue/supervision required
☐ **Severely Impaired:** Never/Rarely Makes Decisions

Please check all that apply:
☐ **Disoriented** ☐ **Agitated** ☐ **Depressed** ☐ **Anxious** ☐ **Memory Loss**
☐ **Wander** ☐ **Verbally Aggressive** ☐ **Physically Aggressive** ☐ **Resists Care** ☐ **Other**

Has patient been hospitalized for Psychiatric Diagnosis? ☐ **Yes** ☐ **No** **(If yes, give details below.)**
Date: _____ **Hospital:** _____ **Diagnosis:** _____

_____

If nursing home placement is medically necessary, will the patient be likely to return to the community within 6 months? ☐ **Yes** ☐ **No**

Provider's Name (print) _____ **Signature:** _____ **Date:** _____
(MD, DO, RNP, PA)

For Office Use Only

Social Caseworker: _____ District Office: _____
Date form Sent to Provider: _____ Date Received: _____