Received By: Phone ☐
Fax ☐
Email ☐

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 ☐
5.	MARITAL STATUS	1. Never Married 3. Widowed 5. Divorced 2. Married 4. Separated ☐
6.	CITIZENSHIP	1. US Citizen 2. Legal Alien 3. Other ☐
7.	PRIMARY LANG	0. English 2. Spanish 1. French 3. Other ☐
7A.	INTERPRETER REQUIRED	0. No 1. Yes 2. unknown ☐
8.	Race/Ethnicity *(Optional)*	1. Am Indian/Alaskan 2. Asian 3. Black 4. Hispanic/Latino 5. White 6. Other____ 7. Hawaiin/Pacific ☐
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 ☐ Not Known
14.	LEGAL GUARDIAN	Does the applicant have a legal guardian? 0. No 1. Yes 2. Not Known ☐
15.	REFERRAL INFORMATION	Is applicant aware of referral? 0. No 1. Yes ☐
16.	VISUAL/ HEARING	a. Visual Impairment 0. No 1. Yes ☐ b. Hearing Loss 0. No 1. Yes ☐
17.	COGNITIVE/ BEHAVIOR	a. Cognitive Impairment 0. No 1. Yes ☐ b. Behavioral Probs 0. No 1. Yes ☐
18.	ADVANCED DIRECTIVES *(For only those items with supporting documentation)*	*(Click all that apply)* a. Living will ☐ b. Do not Resuscitate ☐ c. Do not hospitalize ☐ d. Organ Donation ☐ e. Autopsy Request ☐ f. Feeding restrictions ☐ g. Medication restrictions ☐ h. other ☐ i. None of the Above ☐

19. CURRENT COMMUNITY CARE PLAN ☐ n/a

PROVIDER	SERVICE CATEGORY *SEE CODING SHEET*	FREQUENCY *# HOURS,/VISITS PER MONTH*	DURATION START DATE	DURATION 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 ☐
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 ☐
22.	PROVIDER REFERRAL	a. Referring Provider/Facility Name ☐N/A _____ b. Provider Contact Name_____ c. Telephone No. _____ d. Fax No._____
23.	PERSONAL/ OTHER/ REFERRAL	a. Referred By: _____ ☐N/A b. Contact Name:_____ c. Telephone No. _____
24.	ASSESSMENT TRIGGER	1. Service Need 4. Financial Change 2. Reassessment Due ☐
25.	ASSESSMENT TYPE	1. Initial 2. Reassessment Due Date: _____ ☐
26.	PROGRAM ASSESSMENT REQUESTED	1. Long Term Care Advisory 4. MaineCare Day Health I, II, III 5. Consumer Directed PA I, II, III 6. Home Based Care (SCA only) 8. Elderly and Adults HCBS 10. PDN Level I, II, III, VIII 11. Adult Family Care Home 12. PDN V 13. NF Assessment 14. 20 Day Medicare/MaineCare 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 20. Cont. Stay Review 21. Ext Ordinary Circum to NF 23. PDN IV (FPSO) 25. TBI-Brain Injury NF 29. Consumer Directed HBC (SCA only) 30. ALF (HBC V, PDN IX only) 31. Residential Care 32. MFP-Homeward Bound 33. ORC-Other Related Conditions 34. Acquired Brain Injury Waiver ☐
27.	NF/HOSPITAL/ HOME HEALTH DATES	a. Acute care denial date: _____ ☐N/A b. First non SNF date: _____ ☐N/A c. 20th day date:_____ ☐N/A d. Last day pvt. pay:_____ ☐N/A e. Late notification date: 0. No 1. Yes f. Bed hold expire: 0. No 1. Yes g. Admission date: _____ ☐N/A h Discharge date:_____ ☐N/A i. Home health end date: _____ ☐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: