

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.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">APPLICANT NAME</td> <td>First: _____ (MI) _____ Last: _____</td> </tr> </table>	APPLICANT NAME	First: _____ (MI) _____ Last: _____																														
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		i. Other _____	i																																			
16.	NO. IN HOUSEHOLD (Incl. applicant)	Other than in institution/residential care facilities <input type="text"/> <input type="text"/>																																				
17.	RESPONSIBILITY/LEGAL GUARDIAN (For only those items with supporting documentation)	<table style="width: 100%;"> <tr> <td colspan="2">(Check all that apply.)</td> </tr> <tr> <td>a. Legal guardian</td> <td>a</td> <td>d. Family member responsible</td> <td>d</td> </tr> <tr> <td>b. Other legal oversight</td> <td>b</td> <td>e. Applicant responsible</td> <td>e</td> </tr> <tr> <td>c. Durable power attorney/ health care proxy</td> <td>c</td> <td>f. Other</td> <td>f</td> </tr> <tr> <td></td> <td></td> <td>g. Unknown</td> <td>g</td> </tr> </table>	(Check all that apply.)		a. Legal guardian	a	d. Family member responsible	d	b. Other legal oversight	b	e. Applicant responsible	e	c. Durable power attorney/ health care proxy	c	f. Other	f			g. Unknown	g																		
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18.	ADVANCED DIRECTIVES (For only those items with supporting documentation)	<table style="width: 100%;"> <tr> <td colspan="2">(Check all that apply.)</td> </tr> <tr> <td>a. Living will</td> <td>a</td> <td>f. Feeding restrictions</td> <td>f</td> </tr> <tr> <td>b. Do not resuscitate</td> <td>b</td> <td>g. Medication restrictions</td> <td>g</td> </tr> <tr> <td>c. Do not hospitalize</td> <td>c</td> <td>h. Other _____</td> <td>h</td> </tr> <tr> <td>d. Organ donation</td> <td>d</td> <td>i. NONE OF ABOVE</td> <td>i</td> </tr> <tr> <td>e. Autopsy request</td> <td>e</td> <td></td> <td></td> </tr> </table>	(Check all that apply.)		a. Living will	a	f. Feeding restrictions	f	b. Do not resuscitate	b	g. Medication restrictions	g	c. Do not hospitalize	c	h. Other _____	h	d. Organ donation	d	i. NONE OF ABOVE	i	e. Autopsy request	e																
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<p>19. CONTACTS</p> <p>A. Name _____</p> <p>Address _____</p> <p>Relationship _____</p> <p>Telephone _____ Legal Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>B. Name _____</p> <p>Address _____</p> <p>Relationship _____</p> <p>Telephone _____ Legal Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>20. REFERRING PHYSICIAN _____</p> <p>Address _____</p> <p>Telephone _____</p>	<p>CONTINUING PHYSICIAN _____</p> <p>Address _____</p> <p>Telephone _____</p>