Received by: ☐ fax ☐ phone

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 2. Married 3. Widowed 4. Separated 5. Divorced ☐

6. CITIZENSHIP 1. U.S. Citizen 2. Legal alien 3. Other ☐

7. PRIMARY LANGUAGE 0. English 1. French 2. Spanish 3. Other _____ **4. to 87.- See instructions** ☐

7A. INTERPRETER REQUIRED 0-No 1-Yes 2-Not known ☐

8. RACE/ ETHNICITY *(Optional)* 1-Am Indian/Alaskan 2-Asian 3-Black 4-Hispanic/Latino 5-White 6-Other _____ 7-Hawaiian/Pacific Isl ☐

9. RESIDENCE ADDRESS Street_____ City/Town_____ Cnty _____ State_____ Zip _____ Phone (____) _____

10. MAINECARE NO. *(if applicable)* ☐☐☐☐☐☐☐☐☐☐ ☐ 0-NA

11. MEDICARE NO. ☐☐☐☐☐☐☐☐☐☐☐ ☐ 0-NA

12. SOCIAL SECURITY NO. ☐☐☐–☐☐–☐☐☐☐

13. INCOME SUMMARY

Source	Recipient	Amount	Frequency

☐ Not known

14. LEGAL GUARDIAN Does consumer have a legal guardian? 0-No 1-Yes 2-Not known ☐

15. REFERRAL INFORMATION Is consumer aware of this referral? 0-No 1-Yes ☐

16. VISUAL/ HEARING
a. Visual Impairment 0-No 1-Yes ☐
b. Hearing Loss 0-No 1-Yes ☐

17. COGNITION/ BEHAVIOR
a. Cognitive Impairment 0-No 1-Yes ☐
b. Behavioral Problems 0-No 1-Yes ☐

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. CURRENT COMMUNITY CARE PLAN ☐ 0-NA

PROVIDER	SERVICE CATEGORY (SEE CODING SHEET)	FREQUENCY (# HOURS/VISITS PER MONTH)	DURATION START DATE	DURATION END DATE	FUNDING SOURCE (SEE CODING SHEET)

20. REFERRAL SOURCE 1. Nursing Facility 2. Consumer 3. Family member 4. Hospital 5. OIAS 6. Residential Care 7. Provider agency 8. Community agency 9. Advocacy agency 10. Physician 11. Other state agency 12. Other ☐

21. LOCATION AT TIME OF ASSESSMENT 1. Hospital Campus_____ Room #_____ 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 ☐

22. PROVIDER REFERRAL
a. Referring Provider/Facility Name ☐ 0-NA _____
b. Provider Contact Name _____
c. Telephone No._____

23. PERSONAL/ OTHER REFERRAL
a. Referred by (Name)_____ ☐ 0-NA
b. Contact Name (if different) _____
c. Telephone No._____

24. ASSESSMENT TRIGGER 1. Service need 2. Reassessment due 3. Significant medical change 4. Financial change ☐

25. ASSESSMENT TYPE 1. Initial 2. Reassessment Date Due _____ ☐

26. 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. HCBS
8. Elderly HCBS
9. Adults w/ Disability HCBS
10. PDN - Level I, II, III, VIII
11. Adult Family Care Home
12. Extended PDN - Level V
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
24. Independent Housing
25. BI - Brain Injury NF
26. MaineCare Home Health
27. PDN Medication Services
28. PDN Venipuncture Only
29. Consumer Directed HBC
☐

27. NF/HOSPITAL/ HOME HEALTH DATES *(if applicable)*
a. Acute care denial date: _____ ☐ 0 - NA
b. First Non-SNF Date: _____ ☐ 0 - NA
c. Last day private pay: _____ ☐ 0 - NA
d. Late notification date 0 - No 1 - Yes ☐
e. Bed hold expired 0 - No 1 - Yes ☐
f. Admission date: _____ ☐ 0 - NA
g. Discharge date: _____ ☐ 0 - NA
h. Home health end date:_____ ☐ 0 - NA

28. PHYSICIAN Name _____ Address _____ Telephone _____

29. EMERGENCY OR FAMILY CONTACT Name _____ Address _____ Relationship _____ Telephone _____ Legal Guardian ☐ Yes ☐ No

30. COMMENTS