JCOA
Form
MEDSNE
Rev. 6/06

REQUEST FOR MEDICAL ELIGIBILITY DETERMINATION FOR SPECIAL NEEDS EVACUATION

I. RECIPIENT INFORMATION

A. Recipient's Name:	**SS #:**	**Medicaid #:**
B. Address (City, State, Zip Code, Parish)**:**	**C. Responsible Party/Curator:**	
	Address (City, State, Zip Code, Parish):	
Telephone: / **Race:** / **Sex:**		
Medicare#: / **Date of Birth:**	**Relationship:**	**Telephone #:**

D. What are/were the living arrangements: ☐ Own home ☐ Relative's home ☐ Other

E. What previous institutional care (including nursing facilities) has this person received?

Facility:	Date:	Facility:	Date:
Facility:	**Date:**	**Facility:**	**Date:**

F. What home/community-based services have been used/considered: ☐ ADHC ☐ MR/DD ☐ CC ☐ PCA ☐ ELDERLY ☐ HH

G. Why were services not suitable?

H. Requesting nursing home placement: ☐ Temporarily ☐ Permanently

I. Applicant/Responsible Party Signature: X ______________________ **Date:** __________

II. EVACUATION LEVEL OF CARE DETERMINATION

Institutional care may be provided under classifications dependent upon the type and/or complexity of care and services rendered, as well as, the amount of time required to render the necessary care and services. The attending physician must designate the required level of care during a mandatory evacuation by selecting the appropriate level below. Please select one of the following levels of care:

A. ☐ Category II - Intermediate Care– considered medically fragile and unable to withstand the physical strain of transport during a mandatory evacuation. Requires assistance with extensive personal care, ambulation, and mobilization.

B. ☐ Category I - Technology Dependent Care – necessitates the use of a caregiver
Indicate special level, if indicated: ☐ TDC ☐ ID ☐ NRTP (☐ Complex; ☐ Rehab)

C. Is this person recommended to be admitted into a medical facility (hospital, nursing facility, etc.) for at least seven (7) consecutive days? ☐ Yes ☐ No

D. Is this person likely to need services in a medical facility (hospital, nursing facility, etc.) for at least thirty (30) consecutive days? ☐ Yes ☐ No

E. Comments:

Recipient's Name:

III. MEDICAL INFORMATION

A. Diagnosis:

B. Medications: (specify dosage, frequency, and route) **ALLERGIES:**

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

C. Recent hospitalizations: (include psychiatric)

D. Mental Status/Behavior: check Yes or No. If Yes, indicate frequency: 1 = seldom; 2 = frequent; 3 = always

□ Yes	□ No	1. Oriented	□ Yes	□ No	4. Comatose	□ Yes	□ No	7. Hostile
□ Yes	□ No	2. Forgetful	□ Yes	□ No	5. Confused	□ Yes	□ No	8. Combative
□ Yes	□ No	3. Depressed	□ Yes	□ No	6. Wanders			

E. Activities of daily living: (check appropriate box)

SELF	ASSIST	TOTAL			
□	□	□	1. Eating	□ 11. Verbal	□ 16. Impaired vision □ Glasses
□	□	□	2. Bathing	□12. Non-verbal	
□	□	□	3. Personal	□ 13. Bowel Incontinence	□ 17. Impaired hearing
□	□	□	4. Oral Hygiene	□ 14. Bladder Incontinence	□ Hearing aid
□	□	□	5. Ambulation	□ 15. Urinary Catheter	□ 18. Dentures

F. SPECIAL CARE PROCEDURES: (check appropriate box: when appropriate give type, frequency, size, stage, and site)

□	1.	Ostomy care		□	7.	MRSA	
□	2.	Glucose monitoring		□	8.	Diet/tube feeding	
□	3.	Restraints		□	9.	Dialysis	
□	4.	IV's		□	10.	Respiratory	
□	5.	Suctioning		□	11.	Decubitus	
□	6.	Specialized rehab		□	12.	Other	

G. PHYSICAL EXAMINATION:

Height ______ Weight ______ Pulse ______ Resp ______ Temp ______ B/P ______

Lab results HCT ______ HGB ______ U/A ______ Radiology ______

General ______ Head & CNS ______

Mouth & EENT ______ Chest ______

Heart & circulation ______ Abdomen ______

Genitalia ______ Extremities ______

Skin Other

H. Physician's Name (Type or print) ______ Phone ______

Address: ______

Physician's Signature ______ Date ______