Maryland Medical Assistance
Medical Eligibility Review Form DHMH 3871B Addendum
(Optional)

Last Name_____ First Name_____ MI___MA#_____ SSN/DOB _____

Contact Person_____ Phone_____ Fax_____

Secondary/Surgical diagnoses requiring physician and/or nursing intervention that support the client's need for care in a nursing facility, MADC, Waiver, or PACE_____

_____

Other pertinent findings (e.g., signs/symptoms, complications, lab results, etc.)_____

_____

Has the client been hospitalized in the past three months? ☐ Yes (please provide detail below) ☐ No

Date	Name of Hospital	# Days	Reason/Comments

Diet (include supplements)_____

Height_____ Weight_____ Blood Pressure_____ Have any of the above changed recently? ☐ Yes ☐ No

If yes, please explain_____

_____

Please list all medications that the client currently takes.

Medication	Dosage	Frequency	PRN?	Route	Reason	If PRN, how often given in the past **?

Are any of the above medications new, being frequently adjusted, or are there other problems with them? ☐ Yes (please explain) ☐ No

_____

_____

Please provide any addition information as to why you believe the person's health care needs cannot be safely managed outside a nursing facility, or in the absence of medical adult day care, Waiver, or PACE_____

_____

I certify to the best of my knowledge that the information on this form is correct.

Name of Physician or Nurse (please print or type)_____Signature_____ Date_____