STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Hospital Transmittal No. 202
Living at Home Waiver Transmittal No. 18
Managed Care Organization Transmittal No. 74
Medical Day Care Transmittal No. 69
Nursing Home Transmittal No. 217
Waiver for Older Adults Transmittal No. 29
March 16, 2009

TO: Nursing Home Administrators
Area Agencies on Aging
Hospital Administrators
Managed Care Organizations
Living at Home Case Managers
Medical Day Care Centers

FROM: Susan J. Tucker, Executive Director
Office of Health Services

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

SUBJECT: Revised DHMH 3871B

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The Maryland Medical Assistance Program has revised the Medical Eligibility Review Form (DHMH 3871B (Rev. 1/2009)) that is used for medical eligibility determinations for the following program services:

1. Nursing Facility;
2. Medical Day Care Waiver;
3. Waiver for Older Adults;
4. Living at Home Waiver;
5. Traumatic Brain Injury Waiver;
6. Ventilator Care (nursing facility, chronic hospital, or Model Waiver); and
7. Program of All-Inclusive Care for the Elderly.

The revised DHMH 3871B and instructions for completing this form are attached. The primary differences between the current form and the revised form are:

(1) Part A, Question #5 specifically elicits the reason for submitting the request (e.g., new, recertification, transfer, etc.); and
(2) Part D elicits diagnosis information.

Use of the revised 3871B is effective immediately. Through April 30, 2009, either version of the form will be accepted. Effective May 1, 2009, and thereafter, **only** the **newer** version of the form (3871B Rev. 1/2009) will be accepted for medical eligibility requests.

As with the previous 3871B, medical eligibility requests may be made by fax or through KePRO's iExchange system. The iExchange system supports the new format.

Questions regarding this transmittal may be directed to the nursing facility staff specialist at 410-767-1736.

Attachments

cc: Nursing Home Liaison Committee
Hopkins ElderPlus
Maryland Department of Aging
Local Health Departments
Health Facilities Association of Maryland
LifeSpan Network
Maryland Association of Adult Day Services
Maryland Hospital Association

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A Guide to the 3871B

Instructions for Completing the Application to Determine Medical Eligibility for Medical Assistance Long Term Care Programs

Long Term Care and Community Support Services Administration
Office of Health Services
Maryland Medicaid Program

Revised 1/2009

If you have questions, or need further information, please call the Division of Long Term Care
(410) 767-1736

Item # and Description	Explanation/Detailed Instructions
Part A	
1. Requested Eligibility Date	The date you want Medicaid to begin paying for the services. If you don't know, put today's date.
2. Admission Date	The date the individual is admitted to your facility. If the individual is not admitted yet, or you are not a facility, leave this blank.
3. Facility MA Provider #	Maryland MA Provider number or Name of Facility
4. Check Service Type	Check the program for which you are applying. Check ONE only. Please note that for Chronic Hospital and Model Waiver services, use of this form is limited to individuals who are ventilator dependent; all other requests for these services must use the DHMH 3871. For Chronic Hospital or Model Waiver Vent Dependent cases, please also submit the Additional Information, Vent Specific Question, and Patient Comorbidity Rating Scale forms.
5. Check Type of Request	This refers to the purpose for submitting a 3871B. To ensure prompt, appropriate processing, please check one box only. Please note that the following types of requests are used only for certain service types: >Conversion to MA, Medicare ended, and MCO disenrollment: nursing facility and chronic hospital vent dependent services > Readmission – bed reservation expired: nursing facility services only >Transfer to new provider - Nursing facility, Chronic Hospital vent dependent ,and Medical Day Care Waiver >Recertification - Waivers and PACE
	**The "Advisory" box should be checked when the individual does not intend to access MA benefits within the next 30 days, but wishes to know whether he/she may be medically eligible for benefits in the future. This type of request is usually sought when an individual with a community spouse plans to apply for Waiver services in the future and wants to establish a "start date" for purposes of calculating the spousal allowance. It may be used, however, any time an individual wishes to learn his/her current medical eligibility status for future long term care planning. NOTE: Requests for advisory determinations should be mailed to: KePRO, 11350 McCormick Road, Executive Plaza II, Suite 102, Hunt Valley, MD 21031, with a check of money order for $30.00 payable to KePRO.
Part B	
1. Client Information:	This refers to the individual for whom you are requesting a level of care
Last Name, First Name, MI	Individual's last name, first name, and middle initial. If he/she doesn't have a middle initial, or you don't know the middle initial, leave this blank.
Sex	M or F-Circle one. M=Male F=Female
SS#	Social Security number of the individual
MA#	Maryland Medical Assistance (MA) number for the individual. If none, leave blank. If the individual's family/representative has applied to Medical Assistance (by going to the Social Service Department in their county, for example), but they have not yet been assigned an MA number, enter "Pending" in this space. Pending only applies to those individuals who actually have an appointment scheduled or have already met with the Social Service Department
DOB	Individual's date of birth
2. Current Address	Individual's permanent address. Please check whether this is the individual's home address or the address of the nursing facility in which the individual is residing.
Address 1	Street address (e.g., 4 Rosamond Ave)
Address 2	Building number, apartment number, etc. (e.g., Apt 41). If none, leave blank
City, State, ZIP	City and state of residence (e.g., Baltimore, MD). The two-letter abbreviation for state may be used. For ZIP code, the 5-digit code may be used.
Phone	Individual's telephone number –Area code and 7-digit phone number (e.g., 410-555-5555)
If in a facility, name of facility	For individuals who are currently living in a facility.

Item # and Description	Explanation/Detailed Instructions
If in acute hospital, name of hospital	Complete only if the individual is currently in an acute hospital awaiting discharge.
3. Next of Kin/Representative	The individual's next of kin or legal representative/guardian. This person will get copies of all denial letters. If you cannot determine the next of kin, write "unknown." Refer to directions under #1 (Client Information) for completing address and phone information for the next of kin.
4. Attending Physician	The primary care physician of the individual (i.e., the physician who provides routine preventive and ongoing care to the individual). Refer to directions under #1 (Client Information) for completing address and phone information for the attending physician.

Part C	
1. Is there a diagnosis of Mental Retardation/related condition, or has the client received MR services within the past two years?	**Note:** "related condition" means a condition that manifests itself before age 22 and causes severe, chronic disability that is likely to continue indefinitely and is attributable to cerebral palsy, epilepsy, or a condition closely related to mental retardation (not including mental illness). Has the individual had a diagnosis of mental retardation or related condition identified by a physician? If so, check YES. Has the individual received any MR services during the past two years, whether or NOT they have a written diagnosis of MR? If so, check YES. Otherwise check NO.
2. Is there any presenting evidence of mental illness?	**Note**: dementia/Alzheimer's is NOT considered a mental illness. Has this individual been diagnosed by a physician with a serious mental illness diagnosable under DSM-III? If so, check YES. Otherwise check NO. If you check YES, check one or more types of mental illness diagnosed.
3. Has the client received inpatient services for mental illness within the past two years?	If the individual has actually been admitted to a psychiatric hospital or unit for inpatient care (not psychiatric day treatment or emergency room) within the past two years, check YES. Otherwise check NO.
4. Is the individual on any medication for treatment of a major mental illness or psychiatric diagnosis?	If the individual is on medication for treatment of serious mental illness (e.g., psychotropic medication, tranquilizers, antidepressants), check YES. Otherwise check NO. If you answered YES to this question, please answer question 4a.
4a. If YES, is the mental illness or psychiatric diagnosis controlled with medication?	If the medication has stabilized the unwanted symptoms for this individual, check YES. If not, or if the physician is still adjusting dosages, or if the answer to question 4 is NO, check NO.
5. Is the client a danger to self or others?	If the individual's behavior indicates that he/she might place himself/herself or someone else in danger, check YES. Otherwise check NO. This question focuses on behavior. The inability to prepare meals, eat an adequate diet, perform routine activities of daily living, or take medications as directed due to dementia or physical limitations does not constitute a behavior problem.

Part D	
1. Primary diagnosis related to the need for requested level of care	Please provide an International Classification of Diseases (ICD-most recent version) code and description of the individual's primary diagnosis that is related to the need for the level of care requested.
2. Other active diagnoses related to the need for requested level of care	Please provide descriptions of other diagnoses that are currently under treatment or otherwise directly affect the individual's need for the requested level of care

Item # and Description	Explanation/Detailed Instructions

Part E	
Table I-Skilled Services	**These complex services require a physician's order and the skill of technical or professional personnel such as a registered nurse, licensed practical nurse, respiratory therapist, physical therapist, and/or occupational therapist. The service must be inherently complex such that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. They cannot be performed by an untrained caregiver.** **For each space, fill in the number of days per week the individual receives the service (0-7). There must be a number entered in the space. Items listed under Rehabilitation and Extensive Services may overlap.**
1. Tracheotomy care-all or part of the day	If the individual has a tracheotomy and any care is provided by the staff for that trach, at least once a day, it counts as ONE day. (e.g., if you provide trach care at least once a day on every day of the week, enter a 7.)
2. Suctioning-Not including routine oral-pharyngeal suctioning, at least once a day	This is deep endo-tracheal suctioning. It does not include suctioning saliva from the mouth or nasal passages (e.g., if you have to suction the trachea at least once a day on every day of the week, enter a 7. If you only have to suction 3 days a week, enter a 3).
3. IV Therapy: Peripheral or Central (not including self-administration)	Fill in the number of days per week the individual will be receiving IV therapy or IV medications (0-7). This number should be a zero (0) unless the individual will continue to receive the IV therapy in the nursing facility, medical day care, waiver, or PACE program. If the IV therapy is only given in the hospital and will be discontinued upon to discharge, or if the individual is able to administer the IV therapy himself/herself, enter a zero (0).
4. IM/SC Injections: At least once a day (not including self-administration)	If the individual receives an injection, ordered by the physician and given by the staff and is unable to administer the injection himself/herself, fill in the number of days per week at least one injection is given (0-7). If the individual will not be receiving the injection in the nursing facility, medical day care, waiver, or PACE program, or is able to administer the injection himself/herself, enter a zero (0).

Item # and Description	Explanation/Detailed Instructions
5. Pressure Ulcer: Stage 3 or Stage 4 **AND** one or more skin treatments (including pressure relieving bed, nutrition or hydration intervention, application of dressing and/or medication)	**Note**: "Stage 1" means demarcated, reddened area of the skin characterized by unbroken skin surface which feels warm, blanches to the touch and does not fade within 30 minutes after pressure has been removed. "Stage 2" means reddened area with a skin break involving partial thickness ulceration of the epidermis and a portion of the dermis with superficial circulatory and tissue damage. There is removal of an area of skin. Drainage is usually serous fluid. "Stage 3" means full thickness loss of skin which may or may not include the subcutaneous tissue level, produces serosanguinous drainage and is surrounded by inflamed skin. "Stage 4" means full thickness loss of skin with invasion of deeper tissue such as fascia, muscle, tendon, or bone; this consists of a deep, broken area with necrosis and white or gray soft tissue. Drainage is usually purulent and foul-smelling secondary to infection. The surrounding area may be inflamed and warm to touch. This stage may also include "tunneling" in which the area forms deep, narrow tunnels into the surrounding tissue. If the individual has a Stage 3 or Stage 4 pressure ulcer (an ulcer caused by pressure, not trauma), regardless of how many other pressure ulcers they might have AND receives an aseptic treatment to the Stage 3 or Stage 4 pressure ulcer area, ordered by a physician, fill in the number of days the treatment is given per week (0-7). If the individual has a Stage 1 or Stage 2 pressure ulcer and no Stage 3 or Stage 4 ulcer, enter a zero (0). If the individual does not receive a treatment ordered by the physician for a pressure ulcer, enter a zero (0). If the individual has a Stage 3 or Stage 4 pressure ulcer and is on a pressure-relieving bed (e.g., Clinitron or other) enter a seven (7). This does not include routine eggcrate or air mattresses. "Nutrition or hydration intervention" means tube feedings, IVs or special feedings recommended by a dietician and ordered by a physician, several times a day. These special feedings must be administered or monitored by a nurse or physician. (This does NOT mean routine oral supplements, such as Ensure.) "Treatment" means application of an aseptic dressing and/or medication to the pressure ulcer. This treatment must be ordered by a physician.
6. Wound Care: Surgical wounds or open lesions with one or more skin treatments per day	"Wound care" means any other kind of open wound that isn't a pressure ulcer. This includes but is not limited to non-healing surgical wounds, stasis ulcers, severe open cellulites, etc. This does NOT include minor skin rashes for which a topical treatment is ordered. "Skin treatments" means application of an aseptic dressing and/or medication to a wound skin area. The treatment must be ordered by a physician. Fill in the number of days per week the individual will be receiving treatment (0-7). If the individual is not receiving treatment for the wound area, enter a zero (0).
7. Tube Feedings: 51% or more of total calories or 500cc or more of fluid intake via tube	Tube feedings are feedings ordered by a physician and administered by NG (nasogastric)/G (gastric) tube. The individual must receive at least 51% of his/her total daily caloric intake or 500 cc of fluid intake daily in order for it to count as a day. Fill in the number of days per week the individual receives tube feedings as defined above (0-7).

Item # and Description	Explanation/Detailed Instructions
8. Ventilator care: Individual would be on a ventilator all or part of the day.	Fill in the number of days per week the individual would be on a ventilator all or part of the day (0-7).
9 Complex Respiratory Services: Excluding aerosol therapy, spirometry, postural drainage or routine continuous O2 usage	The individual is receiving respiratory services that require the supervision or direct care of a respiratory therapist, physical therapist or registered nurse. (e.g., an individual with frequent (more than once a week) bouts of respiratory failure or an individual on oxygen that is more than 2-3L/min maintenance, where monitoring, such as frequent blood gas measurements, by a health care professional is required). It includes, but is not limited to, an individual receiving IPPB or chest PT or nebulizer treatments requiring monitoring (not hand-held nebulizers). It includes but is not limited to individuals who require specialized instruction to be able to function within their own respiratory limitations (i.e., utilizing necessary equipment or receiving chest PT). Enter the number of days per week the individual will be receiving complex respiratory treatment (0-7).
10.Parenteral Feeding or TPN: Necessary for providing main source of nutrition	The individual receives nutrients into the blood stream intravenously. The individual has a central catheter, a PICC line or another type of peripheral line through which they are receiving necessary nutrition. Fill in the number of days the individual is receiving the feeding (0-7).
11. Catheter Care: Not routine Foley	Fill in the number of days per week the individual with a urinary catheter (Foley, suprapubic) requires more care than just routine emptying, cleansing or changing. The catheter would require, but is not limited to, frequent changes (once a week or more), irrigations at least two (2) times a week.
12. Ostomy Care: New	The individual has a new ostomy (less than 60 days old) and requires treatment to the stoma (non-healing or infected) with dressing and/or medication. The individual with a new ostomy needs assistance with changing the bag, cleansing and monitoring of the healing of the stoma; is not able to care for ostomy without assistance of another person. Fill in the number of days per week ostomy care is given (0-7). If the ostomy is not new (i.e., over 60 days old), it will be addressed under continence in Part E.
13. Monitor Machine: (for example, bradycardia or apnea)	The individual is on a monitor that will be used in the nursing facility, medical day care, waiver, or PACE setting, not in the acute hospital setting. This does not include blood pressure monitoring, blood glucose monitoring, or CPAP at night. If the monitor is used only in the hospital setting and will be discontinued upon discharge, enter a zero (0). Fill in the number of days the monitor is used per week (0-7).
14. Formal Teaching/Training Program: Teach client or caregiver how to manage the treatment regime, perform self care or treatment skills for recently diagnosed condition **(must be ordered by a physician)**	This is a program ordered by the physician to teach the individual or the family how to manage the treatment regime, perform self-care or treatment skills for a recently diagnosed condition (e.g., teaching self-injection and blood glucose monitoring for a newly diagnosed diabetic). Fill in the number of days per week during which there is formal teaching or training (0-7).

Item # and Description	Explanation/Detailed Instructions

Table II- Rehabilitation	PT, OT and Speech Therapy Services. Must be current, ongoing treatment and must be necessary to restore function. Services must be provided or overseen by a licensed physical, speech, or occupational therapist.
15. Extensive training for ADLs (restoration, not maintenance) including walking, transferring, swallowing, eating, dressing and grooming	This is restoration, not maintenance. The therapy is restoring one or more ADLs (walking, transferring, swallowing, eating, dressing or grooming) to previous improved level of independence. Fill in the number of days per week the individual receives therapy services (0-7).
16. Amputation/Prosthesis Training: For new amputee	The individual receives therapy for a new amputation or training by a therapist in the use of a new prosthesis. Fill in the number of days per week the individual receives this therapy (0-7).
17. Communication Training: For new diagnosis affecting the ability to communicate	This is an individual who has lost the ability to communicate due to a recent illness or injury (e.g., stroke, accident). The individual receives therapy by a speech therapist or occupational therapist to train/re-train him/her to speak again or communicate in some way. Fill in the number of days per week the individual receives the therapy (0-7).
18. Bowel and Bladder Retraining Program: not including routine toileting schedule	The individual WAS continent prior to an acute illness or injury and now is NOT continent. Training is ordered by the physician and is provided by and monitored closely by a professional therapist or nurse to restore continence as much as is possible. This does not include routine toileting schedules, reminders, or the need to take the individual to the restroom. Fill in the number of days per week this training occurs (0-7).

Part F	
Cognitive Status	
1. Orientation to Person: Individual is able to state his/her own name	If when asked his/her own name, the individual can state his/her name, check YES. If the individual cannot speak, but it is obvious by facial expression or body language that he/she knows his/her own name, check YES. Otherwise check NO.
2. Medication Management: Able to administer the correct medication, in the correct dosage, at the correct frequency without the assistance or supervision of another person.	If the individual does or COULD administer his/her medications, whether or not it is allowed, check YES. Otherwise check NO.
3. Telephone Utilization: Able to acquire telephone numbers, place calls and receive calls without the assistance or supervision of another person	If the individual could make a phone call by himself/herself without the assistance of another person and could dial 911 in case of an emergency, check YES. Otherwise check NO. If the individual can make a phone call but cannot effectively communicate due to a language barrier, check YES.
4. Money Management: Can manage banking activity, bill paying, writing checks, handling cash transactions and making change without the assistance or supervision of another person	If the individual COULD handle all of his/her own financial affairs without assistance, whether or not it is allowed, check YES. Otherwise check NO.
5. Housekeeping: Can perform the minimum of washing dishes, making bed, dusting, laundry and straightening up with the assistance or supervision of another person	If the individual COULD do their own laundry, wash dishes, dust and straighten up the house or apartment, whether or not it is allowed, check YES. If they need help maintaining their house or apartment, check NO.

Item # and Description	Explanation/Detailed Instructions
6. Mini mental exam Was the examiner able to administer the full test?	The mini mental examination is an exam designed to identify dementia and the degree of dementia. There are 17 questions on the exam, for a total of 30 points. You should ask all 17 questions. **The questions must be asked in a language in which the individual is fluent.** Was the examiner able to administer the **entire** test? Check YES or NO. Check YES only if the entire test was administered. If YES, enter the score. If NO, check the closest reason why it was not given. • Visual loss-cannot see the questions • Hearing loss-cannot hear the questions • Loss of Motor Ability-unable to write • Language Barrier-no interpreter available • Refused-the individual refused to take the exam • Less than an 8th grade Education: Cannot understand the questions, not due to dementia, but due to lack of knowledge. If the majority – but not the entirety – of the test was administered, you may write in the partial score if you are using a paper copy of the 3871b. If you do so, please write the score to the left of where the score would be entered for a completed mini-mental exam and submit a copy of the exam itself. The partial score should be reported with a numerator and a denominator based on how much of the exam was complete (e.g., 20/25).
7. Wanders (several times a day) Moves with no rational purpose or orientation, seemingly oblivious to needs or safety	Behavior must be a consistent pattern, not just a one time issue. If the individual is confused and wanders with no purpose two or more times a day, check YES. Otherwise check NO.
8. Hallucinations or Delusions (at least weekly) Seeing or hearing non-existent objects or people, or a persistent false, psychotic belief regarding the self or other people or objects outside of self	Behavior must be a consistent pattern, not just a one time issue. If the individual has hallucinations or delusions (e.g., talks to people who are deceased, sees animals on the floor when there are none, or believes that they are someone they are not, such as the Queen of England) at least once a week, check YES. Otherwise check NO.
9. Aggressive/abusive behavior (several times a week) Physical and verbal attacks on others , including but not limited to threatening others, hitting, shoving, scratching, punching, pushing, biting, pulling hair or destroying property	Behavior must be a consistent pattern, not just a one time issue. If the individual is aggressive or physically or verbally abusive toward other people two or more times a week, check YES. Otherwise check NO.

Item # and Description	Explanation/Detailed Instructions
10. Disruptive/Socially Inappropriate Behavior (several times a week): Interferes with the activities of others or own activities through behaviors including but not limited to making disruptive sounds, self-abusive acts, inappropriate sexual behaviors, disrobing in public, smearing or throwing feces, hoarding, rummaging through others' belongings, constantly demanding attention, urinating in inappropriate places	Behavior must be a consistent pattern, not just a one time issue. If the individual exhibits inappropriate behavior more than two (2) times a week, check YES. Otherwise check NO.
11.Self-injurious behavior (several times a month): Repeated behaviors that cause injury to self; biting, scratching, picking behaviors, putting inappropriate objects into any body cavity (including ear, mouth or nose), head slapping or banging	Behavior must be a consistent pattern, not just a one time issue. If the individual exhibits any form of self-injurious behavior more than two (2) times a month, check YES. Otherwise check NO.
12. Hearing Impaired even with the use of a hearing aid: Difficulty hearing when not in a quiet setting, understands conversations only when face to face (lip-reading), can hear only very loud voice, or totally deaf	If the individual cannot hear with just a moderately raised voice or radio/TV volume, check YES. Otherwise check NO. If the individual can hear with the assistance of a hearing aid, check NO.
13. Vision Impaired even with correction: Difficulty with focus at close range, field of vision is severely limited (tunnel vision or central vision loss), only sees light, motion, colors or shapes, or is totally blind	If the individual cannot see to read or watch TV, even with glasses on, check YES. Otherwise, check NO. If the individual can see enough to read or watch TV with glasses on, check NO.
14. Self-expression: Unable to express information and make self understood using any means (with the exception of a language barrier)	If the individual cannot express his/her own needs in any way, check YES. Otherwise, check NO. If the individual cannot express their needs because you can't understand their language, and there is no interpreter, check NO.

Item # and Description	Explanation/Detailed Instructions

Functional Status	
15. Mobility: Purposeful mobility with or without assistive devices	If the individual needs no assistance in getting around the facility once he/she is up on his/her feet or in the wheelchair (e.g., once up, he/she is then able to move about by himself/herself), enter a zero (0). If the individual just needs some verbal encouragement or supervision/guarding for balance, to begin walking or wheeling wheelchair, enter a one (1). If the individual requires hands-on physical assistance (e.g., you need to help get the walker or wheelchair going and he/she needs some help to move about the facility, enter a two (2). If the individual can help a little bit, but requires a lot of assistance; really couldn't move about the facility without physical assistance of one or two people, enter a three (3). If the individual cannot propel himself/herself around the facility at all; someone needs to push him/her in a wheelchair or geri-chair, enter a four (4).
16. Transferring: The act of getting in and out of bed, chair, or wheelchair. Also transferring to and from the toilet and/or shower	If the individual can transfer himself/herself to and from the bed, chair, toilet or shower independently without any assistance, enter a zero (0). If the individual can move himself/herself, but WON'T move unless you tell him/her to, or just needs someone to stand by to give moral support or supervision/guarding for balance, enter a one (1). If the individual needs limited physical assistance getting to and from the bed, chair, toilet or shower; you just have to hold on to him/her during transfer to make sure balance isn't lost, but the individual is doing most of the work, or can move from bed to chair but not from chair to bed, enter a one (2). If the individual needs physical extensive assistance to move to and from the bed, chair, toilet or shower (two-handed assistance or more than one person to assist) and couldn't accomplish the transfer without help, enter a three (3). If the individual cannot help with the transfer at all; needs lifting to get to and from bed, chair, toilet or shower, enter a four (4).
17. Bathing (or showering): Running the water, washing and drying all parts of the body, including hair or face	If the individual can bathe himself/herself and take care of all cleansing needs, enter a zero (0). If the individual can wash and dry himself/herself but just needs encouragement or supervision to get started or to finish, enter a one (1). If the individual requires some hands on assistance with getting bathed properly, but can help quite a bit during the process, enter a two (2). If the individual requires extensive physical assistance with bathing; might be able to wash own face and hands, but nothing else. Individual would never be able to bathe properly without someone else doing most of the work, enter a three (3). If the individual cannot bathe themselves at all; requires total care, enter a four (4).
18. Dressing: The act of laying out clothes, putting on and removing clothes, fastening of clothing and footwear, including prosthesis, orthotics belts and pullovers	If the individual can prepare clothing for the day and dress himself/herself completely without the assistance of another person, enter a zero (0). If the individual can dress himself/herself but requires some verbal encouragement or supervision to be sure he/she dresses completely and appropriately or needs clothing to be laid out, enter a one (1).

Item # and Description	Explanation/Detailed Instructions
	If the individual requires a limited amount of physical assistance from another person, but can assist with the process (e.g., can dress self, but needs assistance with buttoning buttons or tying laces), enter a two (2). If the individual requires more extensive physical assistance, help with more than half of the dressing process of getting dressed or undressed (e.g., must be assisted to put on pants, shirt or dress), enter a three (3). If the individual cannot dress himself/herself at all and must be dressed or undressed by another person, enter a four (4).
19. Eating: The process of putting foods and fluids into the digestive system (including tube feedings)	If the individual can feed himself/herself without any assistance other than setting tray up or cutting up food, enter a zero (0). If the individual can feed himself/herself with just reminders to keep eating or some encouragement or supervision, enter a one (1). If the individual requires hands-on physical assistance (e.g., may start eating but needs help finishing the meal by actually feeding him/her the remainder of meal), enter a two (2). If the individual requires physical assistance from another person for most of the meal (e.g., might be able to drink from a cup, but requires feeding most of the meal), enter a three (3). If the individual requires feeding totally by another person; would not eat if another person did not feed him/her, OR the individual is tube fed, enter a four (4).
20. Toileting: Ability to care for body functions involving bowel and bladder activity (adjusting clothes, wiping, flushing of waste, use of bedpan or urinal and management of any special devices (ostomy or catheter). **This does not include Transferring (See #16)**	If the individual can manage his/her own toileting hygiene, including wiping, flushing, adjusting clothes or management of an ostomy or catheter, enter a zero (0). If the individual can manage their toileting hygiene as above with only verbal cueing or encouragement or requires supervision to prevent injury, enter a one (1). If the individual requires some assistance with toileting hygiene (e.g., can wipe and flush but needs help with adjusting clothing), enter a two (2). If the individual requires quite a bit of physical assistance with toileting hygiene and can only assist a little bit (e.g., can wipe self, but cannot do anything else), enter a three (3). If the individual cannot manage own toileting hygiene or has an ostomy or catheter and cannot manage the care of it and someone else must do everything for him/her, enter a four (4). This does NOT include transferring to or from toilet. Transferring to and from toilet is addressed in "Transferring" under Functional Ability, Section E., above.
21. Bladder Continence: Ability to voluntarily control the release of urine from the bladder	If the individual is generally continent of urine or may have 1-2 accidents a week, has a catheter and can manage the care of it without assistance, or is able to ask to go to the bathroom prior to an accident, enter a zero (0). If the individual is totally incontinent of urine or has accidents 3 or more times a week, or has an ostomy that requires care by another person or has an indwelling catheter, suprapubic tube or Texas catheter or is only continent because they are maintained on a strict toileting schedule, enter a one (1).

Item # and Description	Explanation/Detailed Instructions
22. Bowel Continence: Ability to voluntarily control the discharge of stool from the bowel	If the individual is continent of stool, or has an occasional accident (once or twice a week), or has an ostomy he/she can care for without assistance from another person, enter a zero (0). If the individual is totally incontinent of stool, has accidents 3 or more times a week, cannot request to go to the bathroom or is only continent because of a strict toileting schedule, enter a one (1). If the individual has an ostomy or catheter that must be cared for by another person, enter a one (1).

Part G	
1. Signature of Person Completing Form	Signature of person completing the 3871B. This is usually a nurse or social worker.
Date	Date of form completion
Printed Name	Print name clearly and include professional degree (e.g., MD, RN)
2. Signature of Health Care Professional	In all cases, except the waiver programs and continued stay review for medical day care, a physician or nurse practitioner must sign this field. In the waiver programs and continued stay review for medical day care, a registered nurse may sign the form.
Date	Date health care professional signed the form
Printed Name	Print name clearly and include professional degree (e.g., MD, RN)

Maryland Medical Assistance
Medical Eligibility Review Form #3871B

Part A – Service Requested

1. Requested Eligibility Date: _____ 2. Admission Date _____ 3. Facility MA Provider #: _____

4. Check Service Type Below:

☐ Nursing Facility ☐ Medical Day Care Waiver ☐ Waiver for Older Adults

☐ Living at Home Waiver ☐ PACE ☐ Model Waiver vent dependent only (all other MW use 3871)

☐ Chronic Hospital vent dependent only (all other CH use 3871)

5. Check Type of Request

☐ Initial ☐ Conversion to MA (NF) ☐ Medicare ended (NF) ☐ MCO disenrollment (NF)

☐ Readmission – bed reservation exp. (NF) ☐ Transfer new provider (NF) ☐ Update expired LOC ☐ Corrected Date

☐ Significant change from previously denied request ☐ Recertification (Waivers/PACE only) ☐ Advisory (please include payment)

Part B – Demographics

1. Client Name: Last _____ First _____ MI ___ Sex: M F (circle)

SS# _____- ____- _____ MA # _____ DOB _____

2. Current Address (check one) ☐ Facility ☐ Home

Address 1 _____

Address 2 _____

City _____ State _____ ZIP _____ Phone _____

If placed in facility, name of facility _____

If in acute hospital, name of hospital _____

3. Next of Kin/ Representative

Last name _____ First Name _____ MI _____

Address 1 _____

Address 2 _____

City _____ State _____ ZIP _____ Phone _____

4. Attending Physician

Last name _____ First Name _____ MI _____

Address 1 _____

Address 2 _____

City _____ State _____ ZIP _____ Phone _____

Applicant Name _____

Part C – MR/MI Please Complete the Following on All Individuals:

Review Item	Answer Y	Answer N
1. Is there a diagnosis or presenting evidence of mental retardation/related condition, or has the client received MR services within the past two years?	☐	☐
2. Is there any presenting evidence of mental illness? Please note: Dementia/Alzheimer's is not considered a mental illness.	☐	☐
a. If yes, check all that apply. ___ Schizophrenia ___ Personality disorder ___ Somatoform disorder ___ Panic or severe anxiety disorder ___ Mood disorder ___ Paranoia ___ Other psychotic or mental disorder leading to chronic disability		
3. Has the client received inpatient services for mental illness within the past two years?	☐	☐
4. Is the client on any medication for the treatment of a major mental illness or psychiatric diagnosis? a. If yes, is the mental illness or psychiatric diagnosis controlled with medication?	☐ ☐	☐ ☐
5. Is the client a danger to self or others?	☐	☐

Part D – Diagnoses

Primary diagnosis related to the need for requested level of care	ICD Code	Description
Other active diagnoses related to the need for requested level of care	Descriptions	

Part E – Skilled Services:

Requires a physician's order. Requires the skills of technical or professional personnel such as a registered nurse, licensed practical nurse, respiratory therapist, physical therapist, and/or occupational therapist. The service must be inherently complex such that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. Items listed under Rehabilitation and Extensive Services may overlap.

Table I. Extensive Services (serious/unstable medical condition and need for service)

Review Item (Please indicate the number of days per week each service is required)	# of days service is required/wk. (0-7)
1. Tracheotomy Care: All or part of the day	
2. Suctioning: Not including routine oral-pharyngeal suctioning, at least once a day	
3. IV Therapy: Peripheral or central (not including self-administration)	
4. IM/SC Injections: At least once a day (not including self-administration)	
5. Pressure Ulcer Care: Stage 3 or 4 and one or more skin treatments (including pressure-relieving bed, nutrition or hydration intervention, application of dressing and/or medications)	
6. Wound Care: Surgical wounds or open lesions with one or more skin treatments per day (e.g., application of a dressing and/or medications daily)	
7. Tube Feedings: 51% or more of total calories or 500 cc or more per day fluid intake via tube	
8. Ventilator Care: Individual would be on a ventilator all or part of the day	
9. Complex respiratory services: Excluding aerosol therapy, spirometry, postural drainage or routine continuous O2 usage	
10. Parenteral Feeding or TPN: Necessary for providing main source of nutrition.	
11. Catheter Care: Not routine foley	
12. Ostomy Care: New	

Applicant Name _____

13. Monitor Machine: For example, apnea or bradycardia	
14. Formal Teaching/Training Program: Teach client or caregiver how to manage the treatment regime or perform self care or treatment skills for recently diagnosed conditions (**must be ordered by a physician)**	

Table II. Rehabilitation (PT/OT/Speech Therapy services) Must be current ongoing treatment.

Review Item (Please indicate the number of days per week each service is required.)	No. of days service is required/wk. (0-7)
15. Extensive Training for ADLs. (restoration, not maintenance), including walking, transferring, swallowing, eating, dressing and grooming.	
16. Amputation/Prosthesis Care Training: For new amputation.	
17. Communication Training: For new diagnosis affecting ability to communicate.	
18. Bowel and/or Bladder Retraining Program: Not including routine toileting schedule.	

Part F – Functional Assessment

Review Item	**Answer**	
Cognitive Status (Please answer Yes or No for EACH item.)	**Y**	**N**
1. Orientation to Person: Client is able to state his/her name.	☐	☐
2. Medication Management: Able to administer the correct medication in the correct dosage, at the correct frequency without the assistance or supervision of another person.	☐	☐
3. Telephone Utilization: Able to acquire telephone numbers, place calls, and receive calls without the assistance or supervision of another person.	☐	☐
4. Money Management: Can manage banking activity, bill paying, writing checks, handling cash transactions, and making change without the assistance or supervision of another person.	☐	☐
5. Housekeeping: Can perform the minimum of washing dishes, making bed, dusting, and laundry, straightening up without the assistance or supervision of another person.	☐	☐
6. Folstein Mini-Mental Results: Was the examiner able to administer the full test? If yes, indicate the final score. If no, indicate reason. (Examination should be administered in a language in which the client is fluent.)	☐	☐ If yes, Score: _____ If No, check one of the following: ☐ Visual Loss ☐ Hearing Loss ☐ Loss of Motor Ability ☐ Language Barrier ☐ Refused ☐ Less than 8th Grade education
Behavior (Please answer Yes or No for EACH item.)	**Answer**	
	Y	**N**
7. Wanders (several times a day): Moves with no rational purpose or orientation, seemingly oblivious to needs or safety.	☐	☐
8. Hallucinations or Delusions (at least weekly): Seeing or hearing nonexistent objects or people, or a persistent false psychotic belief regarding the self, people, or objects outside of self.	☐	☐
9. Aggressive/abusive behavior (several times a week): Physical and verbal attacks on others including but not limited to threatening others, hitting, shoving , scratching, punching, pushing, biting, pulling hair or destroying property.	☐	☐
10. Disruptive/socially inappropriate behavior (several times a week): Interferes with activities of others or own activities through behaviors including but not limited to making disruptive sounds, self-abusive acts, inappropriate sexual behavior, disrobing in public, smearing/throwing food/feces, hoarding, rummaging through other's belongings, constantly demanding attention, urinating in inappropriate places.	☐	☐
11. Self-injurious behavior (several times a month): Repeated behaviors that cause injury to self, biting, scratching, picking behaviors, putting inappropriate object into any body cavity, (including ear, mouth, or nose), head slapping or banging.	☐	☐

Applicant Name _____

Communication (Please answer Yes or No for EACH item.)	**Answer**	
	Y	**N**
12. Hearing Impaired even with use of hearing aid: Difficulty hearing when not in quiet setting, understands conversations only when face to face (lip-reading), can hear only very loud voice or totally deaf.	☐	☐
13. Vision Impaired even with correction: Difficulty with focus at close range, field of vision is severely limited (tunnel vision or central vision loss), only sees light, motion, colors or shapes, or is totally blind.	☐	☐
14. Self Expression: Unable to express information and make self understood using any means (with the exception of language barrier).	☐	☐
Review Item		
FUNCTIONAL STATUS: Score as Follows **0 = Independent:** No assistance or oversight required **1 = Supervision:** Verbal cueing, oversight, encouragement **2 = Limited assistance:** Requires hands on physical assistance **3 = Extensive assistance:** Requires full performance (physical assistance and verbal cueing) by another for more than half of the activity. **4 = Total care:** Full activity done by another	**Score Each Item (0-4)**	
15. Mobility: Purposeful mobility with or without assistive devices.		
16. Transferring: The act of getting in and out of bed, chair, or wheelchair. Also, transferring to and from toileting, tub and/or shower.		
17. Bathing (or showering): Running the water, washing and drying all parts of the body, including hair and face.		
18. Dressing: The act of laying out clothes, putting on and removing clothing, fastening of clothing and footwear, includes prostheses, orthotics, belts, pullovers.		
19. Eating: The process of putting foods and fluids into the digestive system (including tube feeding).		
20. Toileting: Ability to care for body functions involving bowel and bladder activity, adjusting clothes, wiping, flushing of waste, use of bedpan or urinal, and management of any special devices (ostomy or catheter). This does not include transferring (See transferring item 16 above).		
CONTINENCE STATUS: Score as Follows **0 = Independent:** Totally continent, can request assistance in advance of need, accidents only once or twice a week or is able to completely care for ostomy. **1 = Dependent:** Totally incontinent, accidents three or more times a week, unable to request assistance in advance of need, continence maintained on toileting schedule, indwelling, suprapubic or Texas catheter in use or unable to care for own ostomy.	**Score Each Item (0-1)**	
21. Bladder Continence: Ability to voluntarily control the release of urine from the bladder		
22. Bowel Continence: Ability to voluntarily control the discharge of stool from the bowel.		

Part G – Certification

1. Signature of Person Completing Form: _____ Date_____

   Printed Name_____

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

2. Signature of Health Care Professional: _____Date_____

   Printed Name_____