

MEDICAID VENTILATOR DEPENDENT CARE ASSESSMENT

Instructions:

- All fields must be typewritten
- Fax completed form to:

Program Review Division
(517) 241-7813

Beneficiary's Name:	Date of Birth: / /
Prospective Ventilator Unit:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male
Address of Unit: (Street, Suite Number, City, State, Zip)	
Administrator:	
Admissions Coordinator:	

INSURANCE/RESOURCE SOURCE:

Medicaid ID #: Active: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid Health Plan: (Name)	Disenrollment Date / /
Medicare ID #:	Blue Cross/Blue Shield ID #:	Other Insurance: (Name)
Date Benefits Exhausted: / /	Date Benefits Exhausted: / /	Date Benefits Exhausted: / /

DISCHARGE INFORMATION:

<input type="checkbox"/> Hospital	Facility Name:	Admission Date: / /
<input type="checkbox"/> Nursing Facility		
Primary Diagnosis:		Secondary Diagnosis:
Medical History: _____		
Surgeries and Dates: _____		

RESPIRATORY STATUS:

Date Placed on Ventilator: / /	Suctioning Frequency: _____
Number of Hours on Vent (Out of 24 hrs.): _____	Secretion Description: _____
Weaning Potential: _____	Prognosis: _____
Weaning Attempts: _____	
O2 Usage: _____	Level: _____
	Frequency: _____
	Route: _____
NOTE: Medicaid does not reimburse for C-PAP/BI-PAP only.	
Blood Gases: _____	Labs: _____
Medications: _____	

ADDITIONAL DATA:

Mental Status:	Sensory/Communication Status:
Diet Type: _____ <input type="checkbox"/> Tube Feeding	Caloric Intake: _____ Supplements: _____
Status: _____	
Incontinence: Bowel <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment /Therapies: (Check as applicable.) <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> ST
Bladder <input type="checkbox"/> Yes <input type="checkbox"/> No	
Catheter <input type="checkbox"/> Yes <input type="checkbox"/> No	
Wounds: _____	
Comments: _____	
Submitted by: _____	Date: _____
Telephone Number: () -	Fax #: () -
	Pager: () -