**DEPARTMENT OF HUMAN SERVICES**
**ELIGIBILITY ASSESSMENT: LEVEL OF CARE**

NAME: Last_____ First_____ Med. Asst. #_____

D.O.B._____ Sex: ____Male ____Female

Name of Hospital:_____ DOA_____ DOD_____

Admitted From: Name of Facility:_____

Admitted From: Community Address:_____

Diagnoses: Primary_____

_____

Diagnoses: All Other _____

Recommended Level of Care (Check one box):

____NF (Federal Medicare) ____Nursing Facility ____ICF-MR

Duration _____ Denial _____

Waiver: ___DHS ____ICF-MR ____PARI ____SDC ____DEA

Duration _____ Denial _____

_____ Katie Beckett Duration _____

Specify Reasons for Recommended Level of Care (Include medical and nursing needs, functional and mental status):

Discharged To: Name of Facility:_____

Discharged to: Community Address: _____

Form completed by: _____ Date:_____
Signature

Physician sign here to certify patient likely to return home within six months:

_____M.D.
Signature

CP-1
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