OUTCOME

Agency Name: ____________________

Applicant Name: ____________________

Provider-Assessor # [ ][ ][ ][ ][ ][ ][ ][ ][ ] – [ ][ ][ ]

Social Security # [ ][ ][ ] – [ ][ ] – [ ][ ][ ][ ]

Assessment Date: [ ][ ] – [ ][ ] – [ ][ ][ ][ ]

MaineCare # [ ][ ][ ][ ][ ][ ][ ][ ][ ]

SECTION T. ASSESSMENT TYPE/VERSION

1. TYPE — **1.** Initial (original) **2.** Reassessment [ ]

2. VERSION — **1.** Original **3.** Conversion **5.** Reinstated **2.** Revision **4.** Pending appeal **6.** Update [ ]

3. ASSESSMENT/ COMMUNITY PROGRAM ELIGIBILITY — **1. Assessment Requested** from 6B — *Check only one.* **2. Community Program Eligibility** from scoring pages — *Check all that apply.*

1. ASMNT REQUESTED	2. PROGRAM	
		1. Long Term Care Advisory
		2. Adult Day Services
		3. OES Homemaker
		4. MaineCare Day Health I, II, III
		5. Consumer Directed PA I, II, III
		6. Home Based Care
		7. Phys. Dis. HCB
		8. Elderly HCB
		9. Adult w/ Disability HCB
		10. PDN - Level I, II, III, VIII
		11. Adult Family Care Home
		12. Level V - Extended PDN
		13. NF Assessment
		14. 20-day Medicare/MaineCare
		15. Medicare to MaineCare

1. ASMNT REQUESTED	2. PROGRAM ELIGIBILITY	
		16. 20-day copay to NF MaineCare
		17. 30-day Community MaineCare NF
		18. Advisory to MaineCare Update
		19. Adv. Medicare to Private Pay NF
		20. Continuing Stay Review
		21. Extraordinary Circumstances to NF
		22. Katie Beckett
		23. Level IV - NF PDN
		24. Independent Housing
		25. BI-Brain Injury NF
		26. MaineCare Home Health
		27. PDN Medication - Level VI
		28. PDN Venipuncture Only - Level VII
		29. Cons. Directed HBC

4. CONSUMER CHOICE *(Choose one)* — **1.** Community Options **3.** Advisory only **5.** NF **2.** Residential Care **4.** No choice [ ]

5. ADVISORY PLAN — Program referrals given to consumer as an advisory 0 - No 1 - Yes [ ]
Program advisory type is 1-Community 2-NF 3-Both [ ]
Advisory medical eligibility determination is valid for [ ] 30 days [ ] 60 days [ ] 90 days
Valid from: __________ to __________ [ ] 0-NA

6. OPTIONS INFO — The consumer has requested information about the following care plan option(s). *Check all that apply.* [ ] 1-FPSO [ ] 2-Consumer Directed [ ] 3-OES Homemaker
Or one of the following [ ] 0-NA [ ] 4-Not Interested [ ] 5-Undecided

SECTION U. NF MEDICAL ELIGIBILITY

1. Based on this assessment, the consumer appears to be medically eligible for NF level of care. Complete regardless of consumer choice. 0 - No 1 - Yes [ ]

SECTION V. AWAITING PLACEMENT

1. a. FOR: **0.** NA **1.** NF **2.** MaineCare HCB - Elderly, AD **3.** PDN [ ]
b. AT: **0.** NA **3.** Home **1.** NF **4.** Out-of-state **2.** Hospital (*specify*) [ ]
c. Valid eligibility: from __________ to __________ [ ] 0 - NA

SECTION W. NF/HOSP/HHA DATES

1. Acute care denial date: __________ [ ] 0 - NA
2. First Non-SNF Date: __________ [ ] 0 - NA
3. Last day private pay: __________ [ ] 0 - NA
4. Late notification date 0 - No 1 - Yes [ ]
5. Bed hold expired 0 - No 1 - Yes [ ]
6. Home Health end date: __________ [ ] 0 - NA

SECTION X. NF FACILITY

1. a. Will be entering a NF 0 - No 1 - Yes [ ]
b. Is currently in a NF 0 - No 1 - Yes [ ]
c. NF Name: __________ [ ] 0 - NA
d. Eligibility start date: __________ [ ] 0 - NA
e. Reassess date: __________ [ ] 0 - NA
f. End date: __________ (30-day MaineCare only) [ ] 0 - NA
g. Admission date: __________ [ ] 0 - NA

SECTION Y. LATE SUBMISSION

1a. Reason: [ ] a. Provider not chosen [ ] b. Financial pending [ ] c. Consumer request
1b. To: [ ] a. OMS [ ] b. HCCA [ ] c. OES [ ] d. Other
[ ] 0 - NA

SECTION Z. COMMUNITY BENEFITS

FUNDING SOURCE (from Care Plan)	PROVIDER	ELIGIBILITY START DATE	REASSESS DATE	WAIT LIST
				[ ]
				[ ]
				[ ]
RESIDENTIAL CARE REFERRAL				
				[ ]

BENEFITS DENIED

FUNDING SOURCE	ACTION	REASON	10-DAY	DISCHARGE DATE	DISCHARGE TO
			[ ]		
			[ ]		
			[ ]		

NOTICE DATES

Date of denial: __________
[ ] 10-day Date: __________
[ ] 60-day Notice: __________
[ ] Appeal
Reinstate 0 - No 1 - Yes [ ]
Date: __________

SIGNATURE

Assessment Date | Assessment Version | Assessor Signature | Signature Date

FOR OFFICE USE ONLY OES/OIAS

[ ] APRC

OES request date __________ to __________

OIAS approved begin date __________ to __________