Medicaid Long Term Services and Supports
Provider Medical Statement

Your patient is applying for Long Term Services and Supports covered by RI Medicaid. The information you provide on this form will assist the Office of Medical Review to determine the individuals required Level of Care.

I. General Patient Information

Name of Patient (First, Middle, Last, Suffix)	**DOB** / /
Patient SSN or MID#	**Gender**
Mailing Address	**Apt/Lot#**
City	**State** **Zip Code**

Current Living Arrangements: ☐ Home alone ☐ Home with Others ☐ Facility ☐ Homeless ☐ Unknown

If patient is in a facility are they likely to return home within 6 months? ☐ Yes ☐ No ☐ Unknown

II. Current Patient Diagnoses and Infections

Diagnoses

☐ Cerebral Palsy ☐ Dementia ☐ Quadriplegia ☐ TBI ☐ Emphysema/COPD ☐ Renal Failure ☐ Internal Bleeding
☐ Tracheotomy ☐ Chronic Behavioral/Psych Condition ☐ CVA ☐ Congestive Heart Failure ☐ Diabetes
☐ Fractures ☐ Cancer ☐ Osteoporosis ☐ Intellectual Disability or related condition ☐ Neurodegenerative Condition

All Other Diagnosis: _____
Notes regarding diagnosis and impact on functioning: _____
_____
Notes regarding any recent surgeries, including dates:_____
_____

Infections

☐ Pneumonia ☐ Respiratory Infection ☐ Septicemia ☐ UTI ☐ Other: _____

Notes regarding infections: _____
_____

III. Current Patient Problem Conditions

Present in the last 7 days unless otherwise noted.

☐ Dehydration ☐ Dizziness/Vertigo ☐ Recurrent lung aspirations in the last 90 days ☐ Shortness of breath
☐ Syncope/fainting ☐ End state disease (6 months or fewer to live) ☐ Unsteady gait ☐ Vomiting
☐ Other Conditions: _____

Notes regarding conditions: _____

IV. Current Patient Treatments/Special Care

Received during the last 14 days.

☐ Chemotherapy ☐ Dialysis ☐ Ventilator/Respirator ☐ Oxygen Therapy ☐ Radiation ☐ Suctioning ☐ Transfusion
☐ IV Meds ☐Other: _____

Notes regarding special treatment or care: _____

V. Current Therapies

Received during the last 7 days.

☐ Speech ☐ Physical ☐ Occupational ☐ Respiratory ☐ Other: _____

Is the therapy provided for skilled teaching on a daily basis of a least 15 minutes a day? ☐ Yes ☐ No ☐ Unknown

VI. Current Patient Nutrition Issues

Within the last 7 days.

☐ Parenteral/IV ☐ Feeding Tube ☐ Special Diet ☐ Other: _____

VII. Current Patient Status

Is the patient experiencing pain that interferes with daily activity or movement?

☐ No pain/not interfering ☐ Yes, but not daily ☐ Daily, but not constant ☐ All the time ☐ Unknown

VIII. Current Patient Ulcers

Number of Ulcers: Stage 1: _____ Stage 2: _____ Stage 3: _____ Stage 4: _____

In the last 7 days, which skin problems have required treatment? ☐ 2nd or 3rd degree burns ☐ Open lesions other than ulcers or cuts ☐ Surgical wounds ☐None of the above

Notes regarding patient ulcers including size(s): _____

IX. Current Patient Urinary and Bowel Status

Does the patient have urinary incontinence? ☐ No ☐ Yes If yes, how often? ☐ Chronic ☐ Frequent ☐ Occasional

Does the patient have bowel incontinence? ☐ No ☐ Yes If yes, how often? ☐ Chronic ☐ Frequent ☐ Occasional

Does the patient have a diversionary device? ☐ No ☐ Yes If yes, please identify: _____

Does the patient require bladder or bowel training? ☐ No ☐ Yes

Notes regarding bladder or bowel status: _____

X. Psychiatric Status

Within the last 12 months.

Is patient currently receiving psychiatric services? ☐ No ☐ Yes If yes, where: _____

Any recent psychiatric hospitalizations? ☐ No ☐ Yes If yes, where: _____

Notes regarding psychiatric status:_____

_____

XI. Cognition and Memory

Brief Interview of Mental Status: _____/15 **Mini Mental Status Exam: _____/30**

Memory and use of information: (please check one)

☐ Does not have difficulty remembering and using information. Does not require directions or reminders from others

☐ Minimal difficulty remembering and using information. Requires direction and reminding from others 1-3 times daily

☐ Has difficulty remembering and using information. Requires direction and reminding from others 4 or more times/day

☐ Cannot remember or use information. Requires continuous verbal reminding.

Cognitive skills for daily decision making: (please check one)

☐ Independent-decisions consistent/ reasonable

☐ Modified independence- some difficulty in new situations only

☐ Moderately impaired- decisions poor/ cues/ supervision required

☐ Severely Impaired- Never/ rarely makes reasonable/ consistent decisions.

Notes regarding cognition and memory: _____

_____

XII. Prescription Medication

Please attach a current medication list (name, dose, frequency, and route) from patient record.

XIII. Examining Provider Information (MD, PO, RNP, PA)

Printed Name and Credentials:

_____

Signature: _____Date: _____/_____/_____

Date of Patient's Last Office Visit: _____/_____/_____