



**UPCAP LONG TERM CARE PROGRAMS
RELEASE OF CONFIDENTIAL MEDICAL INFORMATION**

PHYSICIAN: _____
ADDRESS: _____

CLIENT: _____

D.O.B: _____ / _____ / _____

SS#: _____

MA RECIPIENT ID # _____

The above-named person has been assessed and deemed eligible for enrollment into UPCAP's Care Management Program. The medical information being requested is necessary to validate medical eligibility and is also useful in determining service eligibility. We request this information based on your knowledge of the above named individual and to facilitate our development of a service care plan.

DIAGNOSIS: Primary: _____
 Secondary: _____

Chronic Illness: Yes _____ No _____

DATE INDIVIDUAL WAS LAST SEEN: _____

Estimated number of months which medical treatment will be required for the diagnosis: _____

Estimated number of office / clinic visits: _____ X PER _____ Week _____ Month _____ Other Specify _____

Will this change? YES _____ (When _____) NO _____

CURRENT MEDICATIONS: (PER CLIENT REPORT, **IF CHANGES OR ADDITIONS, PLEASE LIST**)

NAME AND STRENGTH	FREQ.	PRESCRIBING M.D.	NAME AND STRENGTH	FREQ.	PRESCRIBING M.D.
SEE ATTACHED MEDICATION LIST					

ALLERGIES _____

TREATMENT PRESCRIBED: _____

AMBULATORY STATUS: (1) Independently (2) With Assist (3) Non-Ambulatory

PROGNOSIS: _____

RECENT SURGERY DATE: _____ If applicable, please describe: _____

DIET: .

MD APPROVES USE OF HOME DELIVERED MEALS: YES _____ NO _____

CONTINUED ON REVERSE SIDE

DOES INDIVIDUAL REQUIRE SPECIAL TRANSPORTATION? YES ___ NO ___

DOES INDIVIDUAL NEED TO BE ACCOMPANIED TO MEDICAL APPOINTMENTS? YES ___ NO ___

UPCAP'S SUPPORTS COORDINATORS ASSESSED THE NEEDS IN THE BELOW CATEGORIES:

PERSONAL CARE ACTIVITIES:	SERVICES NEEDED:
<input type="checkbox"/> Eating	<input type="checkbox"/> Specialized Feeding
<input type="checkbox"/> Meal Preparation	<input type="checkbox"/> Range of Motion
<input type="checkbox"/> Transferring	<input type="checkbox"/> Suctioning
<input type="checkbox"/> Bathing	<input type="checkbox"/> Catheters or leg Bags
<input type="checkbox"/> Laundry	<input type="checkbox"/> Bed sore Prevention
<input type="checkbox"/> Taking Meds	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dressing	
<input type="checkbox"/> Toileting	
<input type="checkbox"/> Shopping/Errands	
<input type="checkbox"/> Mobility	
<input type="checkbox"/> Grooming	
<input type="checkbox"/> Housework	

COMMENTS:

DO YOU AGREE AND CERTIFY NEED FOR ASSISTANCE? ___ YES ___ NO

**ADDITIONAL COMMENTS / HISTORICAL BACKGROUND WHICH MAY BE BENEFICIAL IN SERVING OUR CLIENT:

NOTE: Client is no longer in the work force.

By my signature, I attest that the above-named individual meets the nursing facility level of care as established by the Michigan Department of Health and Human Services, and that the person desires to participate in UPCAP's Care Management/Waiver Program.

Physician Signature: _____ **Date:** _____

CLIENT AUTHORIZATION OR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I, _____, am voluntarily participating in UPCAP's LTC Programs. I have been informed of this request for medical information and hereby authorize release of all medical records and relevant information which may be requested as a result of my participation in this program. This authorization will expire on _____.

Client's (Authorized Representative) Signature

Date

Witness or Supports Coordinator Signature

Date

PLEASE RETURN THIS FORM (OR A COPY) TO:

UPCAP – Long Term Care Programs

Thank you for your assistance. If you have any questions, please call us at