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:**	
☐ Eating	☐ Dressing	☐ Specialized Feeding	☐ Range of Motion
☐ Meal Preparation	☐ Toileting	☐ Suctioning	☐ Colostomy Care
☐ Transferring	☐ Shopping/Errands	☐ Catheters or leg Bags	☐ Bedsore Prevention
☐ Bathing	☐ Mobility		
☐ Laundry	☐ Grooming	☐ Other_____	
☐ Taking Meds	☐ Housework		

COMMENTS:

DO YOU AGREE AND CERTIFY NEED FOR ASSISTANCE? ☐ **YES** ☐ **NO**

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

NOTE: Client is no longer in the work force.

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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:**_____

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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