NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services

Examination for Medicaid Coverage Person with a Disability

Medicaid coverage is available for eligible patients who are currently disabled according to Social Security's guidelines. The purpose of this form is for the patient's healthcare practitioner to provide their assessment of the patient's condition. **This form must be completed and signed by the health care practitioner. Medical records from the last 12 months that are pertinent to the patient's impairments must be submitted with this form.** This form alone does not meet legal medical record requirements and is not considered medical evidence.

Patient Information

Name of Patient:

Medicaid ID (if known):	Date of Birth:	Gender:

Healthcare Practitioner Information

Name of Healthcare Practitioner:

Address:	Specialty (if any):

Examination Date

Date of Examination:

Diagnoses of Significant Impairment

Diagnosis 1:	Date of Onset:	Anticipated Duration:
Diagnosis 2:	Date of Onset:	Anticipated Duration:
Diagnosis 3:	Date of Onset:	Anticipated Duration:
Diagnosis 4:	Date of Onset:	Anticipated Duration:
Diagnosis 5:	Date of Onset:	Anticipated Duration:

Prognosis

Include any rehabilitation potential.

Specific Details *Check boxes as applicable.*

BASIC ACTIVITIES OF DAILY LIVING		
DRESSING:	☐ does not need assistance	☐ needs assistance
BATHING:	☐ does not need assistance	☐ needs assistance
SELF-FEEDING:	☐ does not need assistance	☐ needs assistance
AMBULATION:	☐ does not need assistance	☐ needs assistance
TOILETING:	☐ does not need assistance	☐ needs assistance
HYGIENE:	☐ does not need assistance	☐ needs assistance

INSTRUMENTAL ACTIVITIES OF DAILY LIVING		
SHOPPING:	☐ does not need assistance	☐ needs assistance
HOUSEKEEPING:	☐ does not need assistance	☐ needs assistance
ACCOUNTING:	☐ does not need assistance	☐ needs assistance
FOOD PREPARATION:	☐ does not need assistance	☐ needs assistance
TELEPHONE USE:	☐ does not need assistance	☐ needs assistance
TRANSPORTATION:	☐ does not need assistance	☐ needs assistance
MEDICATION SET-UP:	☐ does not need assistance	☐ needs assistance

DETAILED NARRATIVE

Describe activities of daily living that need assistance. Add additional pages if needed.

_____ _____

Signature of Practitioner Date of Signature