MEDICALLY FRAIL QUESTIONNAIRE

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1598 (9-2022)

Individuals who are eligible for or are receiving ND Medicaid Expansion Coverage, may complete this Medically Frail Questionnaire to determine if you qualify for the status of medically frail. Individuals who may qualify as being medically frail include those with any of the following:

- serious and complex medical conditions;
- behavioral health conditions (including adults with serious mental illness and/or substance use disorder); and/or
- physical, intellectual, and/or developmental disabilities that significantly impair your ability to perform one or more activities of daily living.

Why might you want to find out if you qualify for the status of Medically Frail -
Based on your health care needs and the services that you require, the status of medically frail would allow you to make a decision about your healthcare coverage and decide which option best meets your needs -
ND Traditional Medicaid or ND Medicaid Expansion. For general information about the differences in benefit coverage offered by each plan, refer to the table on the back of this page.

How can you find out if you qualify for the status of Medically Frail -

- Complete the attached Medically Frail Questionnaire.
- Obtain from the medical provider currently caring for you or your primary care provider the following health care documents - list of medical conditions; current medication list; and any other health care documents which would support your answers on the Medically Frail Questionnaire such as history and physical, consultation reports, or recent progress notes.
- Submit the completed questionnaire and requested health care documents by any of the following ways:
  - Mail: DHHS Medical Services, 600 E Boulevard Ave, Dept 325, Bismarck ND 58505-0250
  - Fax: 1-701-328-1544
  - Email: medicallyfrail@nd.gov

  NOTE: If it is determined that you meet or do not meet the minimum criteria for for medically frail status, you will receive notification. However, if no health care documents were initially submitted a determination cannot be completed, and health care documents will be requested.

  If the health care documents are not received within 30 days of the date, the state sent the form back, your coverage will be or remain as Medicaid Expansion. No additional follow-up will be provided and you will need to submit a new Medically Frail Questionnaire along with the health care documents if you still want a medically frail determination.

How will you know if you qualify for the status of Medically Frail? -
After the review of the Medically Frail Questionnaire and health care documents by a medical professional, you will receive a **determination letter** from the Department of Health and Human Services Medical Services Division. This letter will indicate whether or not you qualify for the medically frail status and include information about next steps as applicable.

IMPORTANT - If you are pursuing a medically frail determination and are or will be utilizing Long Term Care and Support Services Benefits, the provider of those services will need to follow screening requirements and processes as needed for an individual with or pending ND Traditional Medicaid eligibility including, but not limited to, the Preadmission Screening and Resident Review (PASRR) Evaluations, Long Term Care Medical Necessity Screening and ND Medicaid Payment Alert Form.

North Dakota Medicaid Expansion Medically Frail Coverage Plan Options

This table provides general information about the benefits with differences in coverage between ND Traditional Medicaid and ND Medicaid Expansion
(This is NOT an all-inclusive benefit coverage list for either program)

Benefits	ND Traditional Medicaid Out-of-State Services Require Prior Approval	ND Medicaid Expansion MCO Health Plan Services MUST be IN-NETWORK *
Personal Care Services - State Plan Provided in a home or residential setting	• Covered ** • Must meet functional assessment criteria • **Services require prior approval**	• Not covered
Home and Community Based Services (HCBS)	• Not covered ***	• Not covered
Nursing Facility Services or **Swing Bed Services**	• Covered** • MUST meet Level of Care criteria	• Covered-skilled level of care ONLY • Services require prior approval • 30-day limit (consecutive 12-month period)
Nursing Facility Services - Basic Care	• Covered - personal care services ONLY • Must meet functional assessment criteria • **Services require prior approval** • Not covered - room and board ***	• Not covered
Intermediate Care Facilities for Individuals with Intellectual Disabilities	• Covered • MUST meet Level of Care criteria	• Not covered
Dental Office Visits	• Covered • **Certain services require prior approval** • Limit on number of visits and services • Certain services are age restricted	• Not covered
Eye Exam Office Visit Includes optometrists and ophthalmologists	• Covered • **Certain services require prior approval** • Limit on number of visits and services • Certain services are age restricted	• Not covered

* For ND Medicaid Expansion, as indicated above, the services are covered only if provided by a MCO Health Plan IN-NETWORK PROVIDER**.** Services from an out-of-network provider will be covered if any one of the following apply:
- Emergency Services
- Family Planning Services, or
- NO in-Network Provider (must call to obtain prior approval)

Things to consider if you select ND Traditional Medicaid Coverage and utilize Long Term Care Service and Support Benefits -

** A individual will have to submit any gifting or transfer of assets information for the past 5 years. Upon review of the information, a determination will be made as to whether or not ND Traditional Medicaid will provide coverage for these services and/or may need to consider spend down prior to any coverage through ND Traditional Medicaid.

*** A individual will have to submit the North Dakota Health Care Application for the Elderly and Disabled (SFN 958), to determine eligibility for the North Dakota Basic Care Assistance Program or for any waivered services such as Home & Community Based Services (HCBS).

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NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
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Clear Fields

Date

Name	Date of Birth	Home Telephone Number		Cell Phone Number
Home Address	City	State	ZIP Code	County
Mailing Address ☐ Same as Home Address	City	State	ZIP Code	County
Medicaid Number (if known)	Name of Local County Social Service Eligibility Worker (if known)			

Complete this section ONLY - If someone other than yourself should be contacted if additional information is needed or with the determination as to whether or not you qualify for the status of medically frail.

Name	Relationship/Title/Position		
Name of Facility/Organization (if applicable)	Telephone Number		
Address	City	State	ZIP Code

Must include the ***Authorization to Disclose Information Form*** (SFN 1059) in order for any information to be released or shared. This form is available at https://www.nd.gov/eforms/Doc/sfn01059.pdf.

Social Security DISABILITY Benefit Eligibility

☐ **YES - I have been determined by Social Security to be disabled and/or receiving Social Security Disability Benefits**

If YES - have you been DENIED ND Traditional Medicaid under the category of Aged/Blind/Disabled? ☐ Yes ☐ No

If NO - you will need to complete and submit the ***Health Care Application for the Elderly and Disabled*** (**SFN 958**)

☐ **NO - I have not been determined by Social Security to be disabled**

If NO - indicate one of the following:

- ☐ Have not applied and will not be applying for Social Security Disability Benefits
- ☐ Have or will be applying for Social Security Disability Benefits
- ☐ Previously applied and been denied - are or will be appealing the decision
- ☐ Previously applied and been denied - not planning to appeal the decision

Does the following statement apply to you today?
***A detailed explanation is required.**

In the **last 6 months**, I have experienced a catastrophic event caused by an illness or injury resulting in a debilitating medical situation which will or likely require prolong need for medical care and recovery - such as, but not limited to, coma, stroke, heart attack, cancer, or severe accidental injury

Briefly explain situation:

Name	Date of Birth

General Health and Needs

1. In general, compared to other people your age, how would you rate your health (select only one box)?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. In general, compared to other people your age, how would you rate your mental health (select only one box)?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

3. **Are you receiving help** (or if you are currently in a facility/institution - would require help if discharged) **for any of the following activities on a DAILY BASIS from family or friends and/or any agency or provider?** (answer YES or NO for each activity listed)	Yes	No
Personal Hygiene/Grooming - such as someone needing to help brush your teeth, wash your face, comb your hair	☐	☐
Assistance Walking (or if you use a wheelchair, help once seated in the chair) - such as someone needing to hold your arm or push your wheelchair	☐	☐
Help Transferring from One Place to Another - such as moving from chair to bed, chair to toilet, chair to standing position or bed to standing position	☐	☐
Help Eating (includes needing to use a feeding tube) - such as someone needing to feed you with a fork or spoon	☐	☐
Managing Medication - such as someone providing reminders to take medication, opening bottles, taking correct dose, or giving injections	☐	☐

Use of Hospitals, Emergency Rooms, and Clinics

4. In the l**ast 6 months**, how many times did you stay one or more nights in a **HOSPITAL?**

☐ Unknown ☐ Not been hospitalized in the last 6 months ☐ 1 Time ☐ 2 Times ☐ 3 Times

5. In the **last 6 month** have you been hospitalized in a hospital or nursing facility **continuously for 45 days or greater**?

☐ Unknown ☐ Yes ☐ No

6. If hospitalized, were any of those **hospital stays related to MENTAL HEALTH**?

☐ Unknown ☐ Not been hospitalized in the last 6 months ☐ 1 Time ☐ 2 Times ☐ 3 Times

7. In the **last 6 months**, how many times have you used an **EMERGENCY ROOM (ER)**?

☐ Unknown ☐ Not used the ER in the last 6 months ☐ 1 Time ☐ 2 Times ☐ 3 Times

8. In the **last 6 months**, how many times have you been seen in a **CLINIC** by a doctor or nurse practitioner or physician assistant for a **health concern**?

☐ Unknown ☐ No visits to a clinic in the last 6 months for health concerns
☐ 1 Time ☐ 2 Times ☐ 3 Times ☐ 4 Times ☐ 5 to 9 Times ☐ 10 or More Times

9. In the **last 6 months**, how many times have you been seen in a **CLINIC** by a doctor or nurse practitioner or physician assistant for a 9. **mental health concern**?

☐ Unknown ☐ No visits to a clinic in the last 6 months for mental health concerns
☐ 1 Time ☐ 2 Times ☐ 3 Times ☐ 4 Times ☐ 5 to 9 Times ☐ 10 or More Times

Name	Date of Birth

Conditions and Special Needs to Get You Better Care

10. Has a doctor, nurse, or other health professional EVER told you that you have had any of the following?
For each, select YES, NO, or Unknown (UNK)

Medical Condition	Yes	No	UNK	Medical Condition	Yes	No	UNK
High Cholesterol	☐	☐	☐	Diabetes	☐	☐	☐
High Blood Pressure	☐	☐	☐	Obesity	☐	☐	☐
Stroke/Cerebral Vascular Accident (CVA)	☐	☐	☐	Severe Joint Pain - Impacting Mobility	☐	☐	☐
Myocardial Arrest	☐	☐	☐	Paraplegic/Quadriplegic	☐	☐	☐
Heart Attack/Myocardial Infarction (MI)	☐	☐	☐	Parkinson's Disease	☐	☐	☐
Chronic Heart Failure (CHF)	☐	☐	☐	Multiple Sclerosis (MS)	☐	☐	☐
Kidney/Renal Disease or Failure	☐	☐	☐	Amyotrophic Lateral Sclerosis (ALS)	☐	☐	☐
Chronic Hepatitis B or C	☐	☐	☐	Other Neurological/Muscular Diseases	☐	☐	☐
Cirrhosis	☐	☐	☐	Tuberculosis	☐	☐	☐
Other Liver Disease or Failure	☐	☐	☐	Sickle Cell Disease/Aplastic Anemia	☐	☐	☐
Asthma	☐	☐	☐	HIV/Aids	☐	☐	☐
Emphysema/COPD	☐	☐	☐	Traumatic Brain Injury	☐	☐	☐
Cystic Fibrosis	☐	☐	☐	Depression	☐	☐	☐
Other Respiratory Disease or Failure	☐	☐	☐	Other Mental Health Conditions:	☐	☐	☐
Cancer - Indicate Type:	☐	☐	☐	Substance Abuse Disorder:	☐	☐	☐
Transplant and/or Transplant Wait List - Indicate Type:	☐	☐	☐	Other Health Conditions:	☐	☐	☐

Living Situation

Note: If you are currently in an acute care setting such as a hospital - indicate what your living situation was prior to entering the acute care setting

- ☐ In a private home, apartment, or rented room
- ☐ In an assisted living center
- ☐ In a nursing home - admission date: _____
- ☐ In a group home for person with physical, mental, or intellectual disabilities
- ☐ Homeless
- ☐ Shelter
- ☐ Other (specify): _____

Are you able to remain at or return to the living situation indicated above?
☐ Yes ☐ No or Unknown **If NO or UNKNOWN**, indicate plans for future living situation:

Are you in an acute care setting such as a hospital?
☐ Yes ☐ No If **YES**, indicate facility name: Admission Date:

Briefly explain anticipated discharge plan:

Are you currently receiving or in need of hospice services?
☐ Yes ☐ No

Signature

☐ **I declare under the penalty of law, the information provided on this questionnaire is correct to the best of my knowledge. I understand the information provided is subject to verification by federal, state and local officials to determine if the information is correct. If any of the information is incorrect, I may be subject criminal prosecution for knowingly providing incorrect information.**

☐ **I understand that by checking this box and typing my name below that I am electronically signing.** If you are the Authorized Representative, you will need to complete and submit the *Authorization to Disclose Information Form* (**SFN 1059**).This form is available at **www.nd.gov/eforms** under the Department of Human Services (DHS) Public Forms.

Signature	Date