

FUNCTIONAL ABILITY REASSESSMENT
Existing Medicaid Clients

To: Caseworker
Address: _____

Phone: _____

Re: Medicaid Client's Name: _____
Care Facility or Home Address: _____
Telephone Number: _____

Dear [Caseworker's Name]_____:

I request reassessment of the functional ability of _____[client's name] under the new Oregon Administrative Rules effective 12/2/02, OAR 411.015.000, ORS 410.070, and a definition of the Medicaid recipient's level of functional impairment within the priority of paid services levels 1-18, OAR 411-015-0010.

Since the initial eligibility assessment, this client's level of functional impairment (OAR 411.015-0005(8)) has changed.

I request that this assessment take place before _____, 2003.

Please forward the results of the reassessment to the undersigned, **[and to the attorney _____, if one is engaged]**.

Dated: _____, 2003.

Medicaid Client's
Representative's Signature
Address: _____

Phone: _____