INCAPACITATED ADULT MEDICAL EVALUATION

Please read the Privacy Act Statement on page 4 before completing the form.

SECTION A. DEMOGRAPHICS/CERTIFICATION (*To be completed by the Sponsor, Parent or Guardian, or Beneficiary*)

1. PATIENT INFORMATION:

a. PATIENT NAME (*Last, First, Middle Initial):*	b. SPONSOR NAME (*Last, First, Middle Initial*):

c. SPONSOR DoD ID #:	d. PATIENT SEX (*select one*):	e. PATIENT DATE OF BIRTH (*YYYYMMDD*):
	☐ Male ☐ Female ☐ Prefer not to answer	

f. CURRENT PATIENT MAILING ADDRESS (*street, apartment number, city, state, zip code, APO/FPO*):

g. PATIENT TELEPHONE NUMBER (*include country code/area code*):	h. PATIENT PERSONAL E-MAIL ADDRESS:

SPONSOR INFORMATION

2b. BRANCH OF SERVICE (*military only*):	2c. STATUS (*select one*):	2a. SPONSOR RANK/GRADE:

2d. SPONSOR E-MAIL ADDRESS:	2e. SPONSOR TELEPHONE NUMBER (*include country code/area code*):

2f. Does Patient reside with sponsor? (*Select one. If no, explain.*) ☐ Yes ☐ No

3a. Are you Dual Military? ☐ Yes ☐ No	3b. Is your spouse former military? ☐ Yes ☐ No	(*Military, if either 3a or 3b is 'YES' complete 3c - 3g below.*)

3c. SPOUSE NAME:	3d. BRANCH OF SERVICE:	3e. RANK/GRADE:	3f. SPOUSE DoD ID #:

3g. Has the family member ever been enrolled in DEERS under a different sponsor's name or DoD ID #?	☐ YES (*complete 3h-3j*) ☐ NO

3h. PRIOR DoD ID #:	3i. PRIOR SPONSOR NAME:	3j. PRIOR BRANCH OF SERVICE:

MEDICAL SUMMARY (*To be completed by a Qualified Medical Provider Section A: Medical/Psychological diagnosis*)

Patient A - Patient Status (*Authorization by patient or parent/guardian included on Page 4 of this form*)

Please complete as accurately as possible using the current ICD Code(s).

DIAGNOSIS INFORMATION

4a. DIAGNOSIS 1:	4b. ICD CODE:	4c. DATE OF INITIAL DIAGNOSIS (*MMYYYY*):

4d. PROGNOSIS (*Select One*): ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED ☐ UNSTABLE

4e. MEDICATIONS:

4e(1). CURRENT MEDICATIONS:	+	-	4e(2). ABLE TO SELF ADMINISTER MEDICATION:	
			☐ Yes	☐ No

4f. Describe the condition and treatment needs. Include dates of episodes of care.

5a. DIAGNOSIS 2	5b. ICD CODE:	5c. DATE OF INITIAL DIAGNOSIS (*MMYYYY*):

5d. PROGNOSIS (*Select One*): ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED ☐ UNSTABLE

5e. MEDICATIONS.

5e(1). CURRENT MEDICATIONS:	+	-	5e(2). ABLE TO SELF ADMINISTER MEDICATION:	
			☐ Yes	☐ No

5f. Describe the condition and treatment needs. Include dates of episodes of care.

PATIENT NAME (*Last, First, Middle Initial*):	SPONSOR NAME (*Last, First, Middle Initial*):	SPONSOR DoD ID #:

6a. DIAGNOSIS 3:	6b. ICD CODE:	6c. DATE OF INITIAL DIAGNOSIS (*MMYYYY*):

6d. PROGNOSIS (*Select One*): ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED ☐ UNSTABLE

6e. MEDICATIONS.

6e(1). CURRENT MEDICATIONS:	+	-	6e(2). ABLE TO SELF ADMINISTER MEDICATION:	
			☐ Yes	☐ No

6f. Describe the condition and treatment needs. Include dates of episodes of care.

7a. DIAGNOSIS 4	7b. ICD CODE:	7c. DATE OF DIAGNOSIS:

7d. PROGNOSIS (*Select One*): ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED ☐ UNSTABLE

7e. MEDICATIONS.

7e(1). CURRENT MEDICATIONS:	+	-	7e(2). ABLE TO SELF ADMINISTER MEDICATION:	
			☐ Yes	☐ No

7f. Describe the condition and treatment needs. Include dates of episodes of care.

PROVIDER INFORMATION

8a. PROVIDER PRINTED NAME OR STAMP:	8b. SIGNATURE:	8c. DATE (*YYYYMMDD*):

8d. TELEPHONE NUMBERS (*Include Country Code/Area Code*)		8e. OFFICIAL E-MAIL ADDRESS:	8f. MEDICAL SPECIALTY:
8d(1). COMMERCIAL:	8d(2). DSN (*Military Only*):		

9. FUNCTIONAL IMPAIRMENTS (*Physical, Mental, or Sensory*)

	IMPAIRMENT WITHOUT SUPPORT:		SUPPORT CURRENTLY PROVIDED BY:	WHAT SUPPORT DEVICE/EQUIPMENT IS REQUIRED:
a. COGNITIVE:	☐ Yes	☐ No		
b. HEARING:	☐ Yes	☐ No		
c. MOBILITY:	☐ Yes	☐ No		
d. COMMUNICATION:	☐ Yes	☐ No		
e. COMATOSE:	☐ Yes	☐ No		
f. OTHER:	☐ Yes	☐ No		

SECTION B. SELF CARE

10. MENTAL STATUS

a. Can the patient identify who they are?	☐ Yes	☐ No	d. If "No" is selected for any item under Mental Status, briefly explain:
b. Can the patient identify where they are?	☐ Yes	☐ No	
c. Can the patient identify the approximate date?	☐ Yes	☐ No	

11. PATIENT SAFETY

a. Is the patient aware of unsafe practices that could cause harm?	☐ Yes	☐ No	c. Summarize any problems regarding personal safety, decision-making ability, and/or additional assistance needed:
b. Does the patient know what to do if neglected?	☐ Yes	☐ No	

PATIENT NAME (*Last, First, Middle Initial*):	SPONSOR NAME (*Last, First, Middle Initial*):	SPONSOR DoD ID #:

12. NUTRITION

a. Can the patient eat from beginning to end? ☐ Yes ☐ No b. Can the patient communicate hunger or the need to eat to others? ☐ Yes ☐ No c. Is there clinically significant deficiency without support (*e.g., G-tube*)? ☐ Yes ☐ No d. Can the patient acquire, store, and prepare food? ☐ Yes ☐ No	e. Summarize any problems or assistance needed:

13. INCAPACITATION (*the state of not having the necessary ability, qualification, or strength to perform some specified act or function*)

a. COGNATIVE/INTELLECTUAL: ☐ Yes ☐ No b. PHYSICAL: ☐ Yes ☐ No c. PSYCHIATRIC: ☐ Yes ☐ No	d . Summarize any problems or assistance needed:

14. LIMITED ABILITY TO CARE FOR

a. SELF: ☐ Yes ☐ No b. PROPERTY: ☐ Yes ☐ No c. FINANCES: ☐ Yes ☐ No	d. Summarize any problems or assistance needed:

15. ABILITY TO LEARN

a. SELF-CARE SKILLS: ☐ Yes ☐ No b. ADAPTIVE BEHAVIORS: ☐ Yes ☐ No c. SOCIAL SKILLS: ☐ Yes ☐ No	d. Summarize any problems or assistance needed:

16. HEALTH CARE

a. Can the patient independently communicate when treatment for illness/injury is needed?	☐ Yes ☐ No
b. Can the patient independently communicate health needs?	☐ Yes ☐ No
c. Can the patient independently manage their own health condition?	☐ Yes ☐ No
17. PROGNOSIS	☐ Good ☐ Fair ☐ Poor
18. CONDITION. Is the condition expected to improve or recover?	☐ Yes ☐ No
If yes, may the improvement occur only with substantial support?	☐ Yes ☐ No
19. INCAPACITY	☐ Permanent ☐ Temporary
20. CLINICAL JUDGMENT: In the assessment/judgment of the medical professional, do the individual's medical conditions, taken as a whole, substantially limit major life activities, including work?	☐ Yes ☐ No
21. LEGAL GUARDIAN STATUS: Is there a legal or court appointed guardian for this person?	☐ Yes ☐ No ☐ In progress ☐ Pending

CERTIFICATION (*Do not certify before the medical provider completes the entire form.*)

22. PARENT/ GUARDIAN OR PERSON OF MAJORITY AGE. By signing below, we certify that the information submitted on this DHA Form 387 is complete and accurate.

a. EXECUTIVE POWER OF ATTORNEY: ☐ Yes ☐ No	b. PRINTED NAME (*Last, First, Middle Initial*):	c. SIGNATURE:	d. DATE (*YYYYMMDD*):

23. CLINICIAN NAME:	24. CLINCIAN SIGNATURE:

INCAPACITATED ADULT MEDICAL EVALUATION

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; Public Law 104-191, Health Insurance Portability and Accountability Act of 1996; Department of Defense Instruction 1342.30, Dependency Determinations for Incapacitated Adult Children.

PURPOSE: DHA will use this information to screen and document physical or mental incapacitation for incapacitated adult children eligibility determinations.

ROUTINE USES: Pursuant to 5 U.S.C. § 552a(b)(3), this information may be disclosed to federal and state agencies to validate demographic data; to the Social Security Administration to verify an individual's identity; to the U.S. Department of Health and Human Services to verify an individual's healthcare eligibility status in accordance with the Affordable Care Act; to federal agencies to conduct computer matching programs; or to contractors in the performance of work related to this system of records. For additional routine uses, please see the following system of records notices: **DMDC 02 DoD, Defense Enrollment Eligibility Reporting Systems (DEERS)** and **EDHA 07, Military Health Information System**.

DISCLOSURE: Providing this information is voluntary; however, failure to do so may delay or prevent eligibility determination.

INSTRUCTIONS

General Information:
DHA Form 387 is completed as part of the medical determination requirement for eligible beneficiaries applying for the Incapacitated Adult Child Program.

The Certification Section on page 3 should be signed AFTER the entire form is completed and the medical provider has reviewed the information for completeness and accuracy.

The parent/guardian or person signs block 22c.

A qualified medical provider is responsible for assessing whether the determinations being made regarding level of incapacitation across the range of domains are within the scope of their practice and their state licensing requirements.

The purpose of the Medical Determination Form is to examine a person's:

- Overall level of incapacitation across several domains;
- Decision-making ability;
- Ability to provide food, clothing, or shelter for one's self;
- Ability to care for one's own physical health;
- Ability to manage one's own financial affairs and property

For the purposes of this form, independent means the individual performs the activity without any assistance or prompting.

This assessment process should assist in the identification of limitations in a person's decision-making and ability to care for and protect self and manage financial affairs. The answers to the questions indicate whether a person appears to have the capacity to make his or her own decisions or whether he or she would benefit from the protections offered by the sponsor. This document provides a standardized approach to gathering information to assist in the assessment of capacity. This assessment process is intended to assess a person's awareness, level of understanding, and functional ability within a variety of areas.

Conducting the Assessment
The following questions are used to identify the awareness, knowledge, understanding, and functional abilities of the patient being assessed. The questions appear as they are listed on the form. For clarification, examples are provided for each question. Complete only Section A, Background Information, if the patient being assessed is comatose. The background information on a comatose patient would be forwarded along with a physician's referral form when there is a guardianship referral to court. Complete the full assessment for all other individuals.

Section A. Demographics/Certification

Item 1. Sponsor and Patient Information

1a. Enter patient name (*Last, First, Middle Initial*).

1b. Enter sponsor name (*Last, First, Middle Initial*).

1c. Enter sponsor DoD Identification Number.

1d. Patient sex (*select one*).

1e. Enter patient date of birth (*YYYYMMDD*).

1f. Enter patient's current mailing address (*where the patient is residing at the time of assessment*), including street, apartment number, city, state, zip code, APO/FPO.

1g. Enter patient telephone number (*include country code/area code*).

1h. Patient personal e-mail address.

Item 2. Sponsor Information

2a. Enter sponsor rank/grade

2b. Select branch of Service from drop down menu (*military only*).

2c. Select status from drop down menu.

2d. Enter sponsor e-mail address.

2e. Enter sponsor telephone number (*include country code/area code*).

2f. Does patient reside with sponsor? (*Select one. If no, explain in block below.*)

3a. Are you Dual Military? (*Select one. If "yes", complete 3c-3g below.*)

3b. Is your spouse former military? (*Select one. If "yes", complete 3c-3g below.*)

3c. Enter spouse name.

3d. Select branch of Service from drop down menu.

3e. Enter rank/grade.

3f. Enter spouse DoD Identification Number.

3g. Has the family member ever been in DEERS under a different sponsor's name or DoD ID Number? (*Select one. If "yes", complete 3h-3j.*)

3h. If "yes" provide prior DoD ID Number.

3i. If "yes", provide different sponsor's name.

3j. If "yes", select prior sponsor's branch of Service.

Items 4 through 7. Diagnosis Information

4a. Enter diagnosis 1.

4b. Enter International Classification of Disease (ICD) Code.

4c. Enter date of initial diagnosis (*YYYYMMDD*).

4d. Select prognosis (*excellent, good, fair, poor, guarded, unstable*).

4e. Medications.

4e(1). Enter current medication(s). Select "+" (plus) button to add additional lines for medication. Select "-" (subtract) button to remove last line.

4e(2). Able to self-administer medication? (*Select one*)

4f. Describe the condition and treatment needs. Include dates or episodes of care.

Item 8. Provider Information

Block 8a. Enter provider printed name or stamp.

Block 8b. Click to digitally sign or sign manually.

Block 8c. Enter date (*YYYYMMDD*).

Block 8d. Telephone Numbers (*include country code/area code)*.

Block 8d(1). Enter commercial telephone number.

Block 8d(2). Enter DSN telephone number *(military only*).

Block 8e. Enter official e-mail address.

Block 8f. Enter medical specialty.

INSTRUCTIONS, cont.

Item 9. Functional Impairments *(Physical, Mental, or Sensory)*. Enter the level of impairment for cognitive, hearing, mobility, communication, comatose, or other impairments and list any adaptive devises used by the patient. Describe how each impairment may adversely affect the ability in self-care management. The following are examples of impairments and adaptive devices:

a. Cognitive - Neurological or biochemical disorder that causes physical or sensory impairments such as memory, tremors, or hallucinations.

b. Hearing - Severe hearing loss and uses hearing aids.

c. Mobility - Partially ambulatory and self-propels with a wheelchair.

d. Communication - Non-verbal speech and may use a communication board to communication.

e. Comatose - A state of profound unconsciousness from which a person cannot be aroused.

f. Other- Any additional impairment not listed above.

Section B. Self Care

Item 10. Mental Status

a. Can the patient identify who they are? — Example: Can the patient communicate his or her first and last name? Nicknames may be used in place of given names.

b. Can the person identify where they are located?— Example: Can the person communicate the current location by name or type of residence (*such as ICF/IID or nursing facility*)? Any accurate description is acceptable, however general or specific. If the patient cannot communicate the location or identifies an inaccurate location, choose No.

c. Can the patient identify the approximate date? — Example: Can the patient communicate which day of the week it is or the month and year, such as May 20__?

d. If "no" is selected for any item under Mental Status, briefly explain. In the area of mental status, the assessor must summarize any problems or any assistance needed.

Item 11. Patient Safety

a. Is the patient aware of dangers or unsafe practices that could cause harm, injury or death? — Example: Does the person know not to touch a hot stove or to evacuate if there were a fire in the room?

b. Does the patient know what to do if neglected? — Example: Does he or she know an appropriate person to tell if neglected?

c. Summarize any problems regarding personal safety, decision-making ability, and/or additional assistance needed. — Document any disagreement among informants or by the patient.

Item 12. Nutrition

a. Can the eat from beginning to end?

b. Can the patient communicate hunger or the need to eat to others? — Example: Can the patient make it known he or she is hungry?

c. Is there clinically significant deficiency without support (*e.g., G-tube*)?

d. Can the patient acquire, store, and prepare food? — Example: Does the patient have the ability to store food appropriately, refrigerate it, if necessary, and cook it?

e. Summarize any problems or assistance needed.

Item 13. Incapacitation. The state of not having the necessary ability, qualification, or strength to perform some specified act or function.

a. Cognitive/Intellectual
b. Physical
c. Psychiatric
d. Summarize any problems or assistance needed.

Item 14. Limited Ability to Care For

a. Self
b. Property
c. Finances
d. Summarize any problems or assistance needed:

Item 15. Ability to Learn

a. Self-Care Skills
b. Adaptive Behaviors
c. Social Skills
d. Summarize any problems or assistance needed.

Item 16. Health Care

a. Can the patient communicate when treatment for illness/injury is needed? — Example: Does the patient discuss to others if not feeling well or seek assistance for emotional or illness treatment?

b. Can the patient independently communicate health needs? — Example: Can the patient communicate to someone else about his or her unique health condition, such as diabetes, and the treatment required for it, such as a specialized diet?

c. Can the patient manage their own health condition? — Example: Can the patient call for appointments and access the health care system?

Item 17. Prognosis (*Select one: good, fair, poor*).

Item 18. Condition. Is the condition expected to improve or recover? (*Select one*)

Item 19. Incapacity (*Select one: permanent, temporary*)

Item 20. Clinical Judgment. (*Select one*). If "yes", complete 21a-b.

Item 20a. Enter the date of onset of the medical conditions that caused such limitations (*YYYYMMDD*).

Item 20b. Was this before the age of 21? (*Select one*). If "yes" selected, complete remainder of 21b and 21c.

Item 20c. If onset of medical conditions was not before age of 21, was it before the patient attained the age of 23? (*Select one*). If "yes" selected, complete remainder of 21c.

Item 21. Legal Guardian Status (*Select one*).

Item 22. Certification. Parent / Guardian or Person of Majority Age. Do not certify before the medical provider completes the entire form. By signing below, we certify that the information submitted on this DHA Form 387 is complete and accurate.

22a. Executive Power of Attorney. (*Select one. Note: not exclusionary*).

22b. Enter printed name (*Last, First, Middle Initial*).

22c. Click to digitally sign or sign manually.

22d. Enter date (*YYYYMMDD*).

Item 23. Clinician Name. Enter clinician name.

Item 24. Clinician Signature. Click to digitally sign or sign manually.