ICF/IID-LEVEL OF CARE ELIGIBILITY DETERMINATION FORM

A. Facility name/address:			
B. Individual's Name		C. D.O.B.	D. Status:620/ 621
E. Individual's Social Security No.		F. Individual's Medicaid CIN	
G. Responsible Medicaid District		H. Provider MMIS Number	
I. Dates of Preadmission Evaluations:	Physical	Social	Psychological

This information must be kept confidential by recipient

INDIVIDUAL ELIGIBLITY DETERMINATION CRITERIA

1. DIAGNOSIS A. Intellectual Disability ☐ B. Epilepsy ☐ C. Autism ☐ D. Neurological impairment ☐ E. Cerebral Palsy ☐ F. Familial Dysautonomia ☐ G. Prader-Willi Syndrome ☐ H. Other

2. DISABILITY MANIFESTED PRIOR TO AGE 22? YES ☐ NO ☐

3. SEVERE BEHAVIOR PROBLEM YES ☐ NO ☐
A. Daily ☐ **B**. Weekly ☐ **C.** Monthly ☐ **D**. Occurred in past 12 months ☐

4. HEALTH CARE NEED: YES ☐ NO ☐		
A. Medical condition which requires daily individualized attention from health care staff	YES ☐	NO ☐
B. Self injurious behavior which necessitates monitoring and treatment	YES ☐	NO ☐
C. Deficit in self-care skills	YES ☐	NO ☐
1. No/extremely limited self-care skills	YES ☐	NO ☐
2. Requires assistance and training in self performing self-care tasks	YES ☐	NO ☐
5. ADAPTIVE BEHAVIOR DEFICIT: YES ☐ NO ☐		
A. COMMUNICATION: YES ☐ NO ☐		
1. Individual has no/extremely limited expressive or receptive language	YES ☐	NO ☐
2. Individual has some expressive or receptive language but requires assistance to communicate	YES ☐	NO ☐
B. LEARNING: YES ☐ NO ☐	YES ☐	NO ☐
1. I.Q. cannot be determined (certified untestable)	YES ☐	NO ☐
2. I.Q. of less than 50	YES ☐	NO ☐
3. Over 21 years of age, person's reading and computation skills are at first grade level or below	YES ☐	NO ☐
4. I.Q. of 50 – 69	YES ☐	NO ☐
5. Over 21 years of age, person's reading and computational skills are at third grade level or below	YES ☐	NO ☐
C. MOBILITY: YES ☐ NO ☐		
1. Individual is non-ambulatory and totally dependent on staff for moving from one place to another	YES ☐	NO ☐
2. Individual has some mobility skills but needs staff assistance and training to increase his/her capacity for moving	YES ☐	NO ☐
D. CAPACITY FOR INDEPENDENT LIVING: YES ☐ NO ☐	YES ☐	NO ☐
1. Individual is completely dependent on others for all household activities	YES ☐	NO ☐
2. Individual needs assistance or training to perform tasks to be contributing member of household	YES ☐	NO ☐
E. SELF-DIRECTION: YES ☐ NO ☐		
1. Individual exhibits frequent (i.e. weekly) misbehaviors requiring individualized programming	YES ☐	NO ☐
2. Individual is completely dependent on others for management of his/her personal affairs within the community	YES ☐	NO ☐
3. Individual exhibits episodic (i.e. monthly) misbehaviors requiring individualized programming	YES ☐	NO ☐
4. Individual needs assistance or training for management of his/her personal affairs within the general community	YES ☐	NO ☐

6. ☐ **ICF/IID** Level of Care Recommended for approval, effective for the period from to	7. ☐ **ICF/IID** Level of Care not recommended	8. Date of Admission
9. Signature of U.R. Coordinator		10. Review Date
11. Signature of Review Physician	12. NPI # of Physician	13. Review Date

14. SECOND STEP REVIEW	Point(s) at issue	Additional Information Provided
15.CRITERIA MET: YES ☐ NO ☐	16. Physician's Signature	17. Date
18. QIDP Signature:		19. Discipline

20. ☐ ICF/IID Level of Care approved	21. ☐ ICF/IID Level of care NOT Approved
22. SIGNATURE DDSOO/RO DIRECTOR OR DESIGNEE	23. DDSOO/RO 24. DATE

Original to individual's file. Copies to RSFO, MA district, DDRO and file.