Clear Form

Initial Level of Care Eligibility Determination
APPLICANT INFORMATION: Initial Waiver Application

Name _____ **Date of Birth** _____ **County** _____ **Resident #** _____
Social Security # _____ **Address** _____
Guardian _____ **Address** _____

Residence when enrolled: (check one)
☐ With family ☐ Licensed home: facility number _____
☐ In own (unlicensed) place ☐ Other: _____

Is the applicant currently receiving residential, supported living, or waiver services? ☐ Yes ☐ No

Waiver Request (check one) ☐ IO ☐ RFW ☐ Level 1 ☐ Community Access Model

Priority status: (check one)
☐ Emergency ☐ Caregiver age 60+ ☐ Deinstitutionalization
☐ Supported living refinancing ☐ Children with intensive needs ☐ Regular waiting list
☐ Adult services refinancing ☐ Adults with intensive needs ☐ Nursing Home

Waiver Enrollment (Slot) Number: (check one)
☐ A new slot number has been added, with ODMR/DD written approval. slot# _____
☐ A slot number that has been used, but the occupant is being replaced.
- Previous Occupant: _____
- Slot/Enrollment Number: _____ Last date of waiver service: _____

ICF/MR WAIVER LEVEL OF CARE: Initial Eligibility Determination

1. The individual meets the minimum criteria for Protective Level of Care ☐ Yes ☐ No

2a. Diagnosed condition(s) that establish(es) the individual's developmental disability (age 6 and above) _____
_____

2b. Developmental delays assessed for individuals birth through age five _____
_____

> Attach a medical evaluation and a psychological/psychiatric evaluation that verify this diagnosed condition. <

3. Was the disability manifested prior to age 22? ☐ Yes ☐ No
4. Is the disability likely to continue indefinitely? ☐ Yes ☐ No

5. Current substantial functional limitations: (Based on functional assessment) Refer to OAC 5101:3-3-07

i. Self Care (age 6+)	☐ Yes	☐ No
ii. Understanding / Use of Language (age 6+)	☐ Yes	☐ No
iii. Learning (age 6+)	☐ Yes	☐ No
iv. Mobility (age 6+)	☐ Yes	☐ No
v. Self-direction (age 6+)	☐ Yes	☐ No
vi. Capacity for Independent Living (age 6+)	☐ Yes	☐ No
vii. Economic Self-Sufficiency (age 16+ only)	☐ Yes	☐ No
viii. 3 developmental delays (birth to age 5 only)	☐ Yes	☐ No

6-7. Skill Acquisition: The individual could benefit from services and supports to promote the acquisition of skills and to decrease or prevent regression in the performance in areas where delays are indicated and agrees to participate in an individualized plan of services and supports. ☐ Yes ☐ No

8. Level of Care Recommendation:
☐ ICFMR/DD ☐ Other _____

9. Proposed Date for Waiver Services to Begin (mm/dd/year): _____

Name:(Please print) _____ **Title:** _____
Signature: _____ **Date:** _____

(ODMRDD USE ONLY)
ICF/MR Level of Care Approved: _____ Denied: _____ **LOC Effective Date:** _____
Span dates (m/dd/year): **Beginning date:** _____ **End date**: _____

_____ _____
QMRP Signature/Date Waiver Manager Signature/Date

ODMRDD Initial LOC Revised 8-03