Attachment B

INSTRUCTIONS FOR COMPLETING THE LEVEL OF CARE RE-EVALUATION FORM

This document provides detailed instructions for completion of the Level of Care (LOC) Re-Evaluation Form. Before payment can be made, the LOC Re-Evaluation form must be completed by the individual's Support Coordinator and approved by the DBHDD Regional Office.

Item 1: **Participant's Name**
Enter the complete name beginning with the Last Name then the First Name of the participant

Item 2: **Social Security Number**
Enter the participant's nine-digit Social Security number.

Item 3: Region
Enter the participant's DBHDD Region

Item 4: Support Plan Effective Date
Enter the start date of the most current ISP

Item 5: **Level of Care Eligibility:** The individual meets one of the following criteria and is eligible to receive the services provided in an ICF/ID. Check the criteria that are met.

1. Check that the individual's disability is an intellectual disability if the individual's waiver eligibility determination indicated eligibility by diagnosis of an intellectual disability.

2. Check that the individual is eligible under the category of "Other Related Condition" if the individual's waiver eligibility determination indicated eligibility by diagnosis of a condition found to be closely related to an intellectual disability and attributable to: (a) cerebral palsy or epilepsy; or (b) any other condition, other than mental illness, which results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with an intellectual disability.

Item 6a: Please check all Disability Conditions that apply to the individual:

Disability Conditions
Ambulation Deficits
Sensory Deficits
Chronic Health Problems
Behavior Problems
Autism
Cerebral Palsy
Epilepsy
Spina Bifida
Prader-Willi Syndrome
Other: _____ (Specify any other disability conditions)

Item 6b: Please check all Major Life Activities that apply to the LOC Re-Evaluation:

Major Life Activities: Check all areas in which the individual has substantial deficits. Note: To meet ICF/ID Level of Care the individual must have substantial deficits in at least two areas if the individual's disability is intellectual disability and in at least three areas if the individual is eligible under the category of Other Closely Related Condition.
Self Care - Basic Activities of Daily Living include: • Bathing and showering (washing the body) • Bowel and bladder management (recognizing the need to relieve oneself) • Dressing • Personal hygiene and grooming (including washing hair) • Eating (including chewing and swallowing) • Feeding (setting up food and bringing it to the mouth) • Toilet hygiene (completing the act of relieving oneself)
Understanding and Use of Language – Impairments in receptive and/or expressive language. This major life activity includes ability to understand others and to fully express oneself in own language (including sign language) with adaptive communication devices if used by individual.
Learning – Limitations in practical and functional academics, such as reading, computation, and telling time. This major life activity includes the ability to apply reasoning and problem solving, learn new tasks, apply to new situations, or adapt to change
Mobility – limitation in one's ability to move the body or one or more extremities independently. This major life activity includes physical movement of one's body from place to place, with adaptive aids if used by individual, and consists of the ability to transfer, to walk, or to be reliant on a wheelchair or scooter for mobility. It does not include vehicle transportation.
Self Direction – limitation in making decisions and setting and carrying out goals independently. This major life activity includes the ability to make decisions that match one's own values and desires.
Capacity for Independent Living – limitation in age appropriate behaviors for the individual to live independently. This major life activity includes ability to prepare food, manage money, clean house, do laundry, work independently or use the telephone with assistive devices if uses them.

Item 7: **Medicaid Eligibility**

Enter the Medicaid number exactly as it appears on the Medicaid card or Form 962. A valid Medicaid number will be formatted in one of three ways:

a. If the member or applicant is in the Medicaid System, the ID number will be the 12-digit number, e.g., 111222333444;
b. If the member or applicant was previously determined eligible by DFCS staff or making application for services, the number will be the 9-digit SUCCESS number plus a "P", e.g., 123456789P; or

c. If the individual is eligible for Medicaid due to the receipt of Supplemental Security Income (SSI), the number will be the 9-digit Social Security number plus an "S", e.g., 123456789S.

Item 8: **Eligibility Determination:** Check the correct statement:

	Individual has met Level of Care Eligibility (1) has a Medicaid number and is (2) eligible for waiver services.
	Individual has not met the Level of Care Eligibility and is not eligible for Waiver Services
	Individual is in an ICF-ID and was referred for Medicaid Eligibility on (enter the date). The result was ___Eligible ____Ineligible Date of Determination: _____

Item 8: Home and Community Based Waiver LOC Re-Evaluation (if applicable)
The individual's Support Coordinator and the Regional Level of Care RN must sign and date this section. The Regional RN reviews the LOC Re-Evaluation form, the ISP, and any accompanying assessment updates to determine whether the person continues to meet the level of care requirement. The Regional RN will sign and date this document after that review. The signature of the Regional LOC RN must be within 30 days of the date the Support Coordinator signed this document

Item 9: Approval Period
This section is completed by the LOC RN and is the time period for which the LOC has been re-certified for Home and Community Based Waiver services. The initial date the completed LOC Re-Evaluation form is received by the DBHDD Regional Office with all additional required documentation for recertification will constitute the earliest re-certification date once approved.

Item 10: ICF-ID Facility Level of Care Re-Evaluation (if applicable)
The facility RN completes the Level of Care Re-Evaluation Form, and signs and dates the form next to the title of this section. The facility RN forwards the completed form, the current individualized program plan, and any accompanying assessment updates to the Regional Level of Care RN for review. The Regional Level of Care RN signs and dates this section. The signature of the Regional LOC RN must be within 30 days of the date the Facility's RN signed this document.

Approval Period: This section is completed by the LOC RN and is the time period for which the LOC has been re-certified for ICF-ID Facility based services. The initial date the completed LOC Re-Evaluation form is received by the DBHDD Regional Office with all additional required documentation for recertification will constitute the earliest re-certification date once approved.

Item 11: Individual/Representative Signature
This section is only completed for individuals residing in the community. The participant should sign or make their mark in this section. The participant's signature should be dated.

If the participant is a minor or has been adjudicated legally incompetent, this block should contain the signature of the legal guardian. That signature should be dated.