Attachment A: Level of Care Re-Evaluation

NAME:	SS#	Region
Support Plan Effective Date:		

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.

	The individual's disability is intellectual disability.
	The individual is eligible under the category of Other Closely Related Condition.

Please check all that Apply:

✓	Disability Conditions	✓	Major Life Activities
	Ambulation Deficits		Self Care
	Sensory Deficits		Understanding and Use of Language
	Chronic Health Problems		Learning
	Behavior Problems		Mobility
	Autism		Self Direction
	Cerebral Palsy		Capacity for Independent Living
	Epilepsy		
	Spina Bifida		
	Prader-Willi Syndrome		
	Other_____		

Medicaid Eligibility:

Individual has a current Medicaid Number. Medicaid # is _____

Eligibility Determination: Check the correct statement:

	Individual has met Level of Care Eligibility (1) has a Medicaid number (2) and is 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 _____ Date The result was: Eligible ____ Ineligible ____ Date of Determination_____

Home and Community Based Waiver Level of Care Re-Evaluation (if applicable)

- ✓ Support Coordinator signs the Level of Care Re-Evaluation
- ✓ LOC Nurse with the Regional Intake and Evaluation Team signs the Level of Care Re-Evaluation

Support Coordinator:	**Date:**
Regional Level of Care RN Signature:	**Date:**
Approval Period:	

ICF-ID Facility Level of Care Re-Evaluation (if applicable)

- ✓ For ICF-ID Facility Level of Care, the Regional Level of Care RN signs the Level of Care Re-Evaluation

Regional Level of Care RN Signature:	**Date:**
Approval Period:	

Individual/Representative Signatures:

- ✓ **This section is only completed for individuals residing in the community**

It is the policy of the State of Georgia that services are delivered in the least restrictive manner that addresses the service needs of the individual while enhancing the promotion of social integration. Further, it is the policy of the State to recognize the recipient's full citizenship and individual dignity; providing safeguards to protect rights, health and the welfare of recipients.

I have been offered waiver services and choose to receive community based supports and services. I understand that I have a choice of enrolled providers.

Individual Signature:	**Date**
Representative (if applicable):	**Date:**