


 STATE OF NEW YORK  
 OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

**ICF/MR-LEVEL OF CARE ELIGIBILITY DETERMINATION (LCED) FORM**  
**For Bridges to Health (B2H) Waiver Participants**

Please refer to the accompanying instructions for information on completing this form.

Name of Individual			
Address		D.O.B.	Status:620/ 621 N/A for B2H Waiver
Responsible Medicaid District		Medicaid No (CIN)	TABS ID
Dates of Pre-enrollment Evaluations:	Physical	Social	Psychological
<b>This information must be kept confidential by recipient</b> <b>ELIGIBILITY DETERMINATION CRITERIA</b>			
<b>1. DIAGNOSIS:</b> A. Mental Retardation <input type="checkbox"/> C. Autism <input type="checkbox"/> E. Cerebral Palsy <input type="checkbox"/> G. Other <input type="checkbox"/> (specify): B. Epilepsy <input type="checkbox"/> D. Neurological impairment <input type="checkbox"/> F. Familial Dysautonomia <input type="checkbox"/>			
<b>2. DISABILITY MANIFESTED PRIOR TO AGE 22:</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>3. SEVERE BEHAVIOR PROBLEM:</b> YES <input type="checkbox"/> NO <input type="checkbox"/> A. Daily <input type="checkbox"/> B. Weekly <input type="checkbox"/> C. Monthly <input type="checkbox"/> D. Occurred in past 12 months <input type="checkbox"/>	
<b>4. HEALTH CARE NEED:</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
A. Individual has a medical condition which requires daily individualized attention from health care staff		YES <input type="checkbox"/>	NO <input type="checkbox"/>
B. Individual displays self-injurious behavior which necessitates monitoring and treatment		YES <input type="checkbox"/>	NO <input type="checkbox"/>
C. Individual has deficits in self-care skills		YES <input type="checkbox"/>	NO <input type="checkbox"/>
1. Extremely limited self-help skills, requires total assistance with self-care tasks		YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Demonstrates some self-help skills, but requires assistance and training in performing self-care tasks		YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>5. ADAPTIVE BEHAVIOR DEFICIT:</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>A. COMMUNICATION:</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
1. Individual has extremely limited expressive or receptive language skills		YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Individual has some expressive or receptive language but requires assistance to communicate needs		YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>B. LEARNING:</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
1. I.Q. score cannot be determined using standardized test measures (certified untestable)		YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. I.Q. score of less than 50		YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. Over 21 years of age, person's reading and computation skills are at first grade level or below		YES <input type="checkbox"/>	NO <input type="checkbox"/>
4. I.Q. score of 50 – 69		YES <input type="checkbox"/>	NO <input type="checkbox"/>
5. Over 21 years of age, person's reading and computational skills are at third grade level or below		YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>C. MOBILITY:</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
1. Individual is non-ambulatory and totally dependent on staff for moving from one place to another		YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Individual has some mobility skills but needs staff assistance and training to increase his/her capacity for moving about		YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>D. CAPACITY FOR INDEPENDENT LIVING:</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
1. Individual is completely dependent on others for all household activities		YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Individual needs assistance or training to perform tasks to be a contributing member of household		YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>E. SELF-DIRECTION:</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
1. Individual exhibits frequent (i.e., weekly) challenging behaviors requiring individualized programming		YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Individual is completely dependent on others for management of his/her personal affairs within the general community		YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. Individual exhibits episodic (i.e., monthly) challenging behaviors requiring individualized programming		YES <input type="checkbox"/>	NO <input type="checkbox"/>
4. Individual needs assistance or training for management of his/her personal affairs within the general community		YES <input type="checkbox"/>	NO <input type="checkbox"/>

See next page for required signatures

