

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
LEVEL OF CARE

**ICF/MR-ELIGIBILITY DETERMINATION FORM
FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES (DD)**

BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

CHILD'S NAME (LAST, FIRST, MI.):		
DATE OF BIRTH:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICAID CIN #:

INSTRUCTION: Based on the following criteria, indicate whether the child, in your clinical opinion, meets the Level of Care requirements for participation in the B2H Medicaid Waiver Program. This form must be completed on an annual basis. This form is part of the Reauthorization Packet that must be sent to the Local Department of Social Services (LDSS) or Division of Juvenile Justice and Opportunities for Youth (DJJOY).

DATES OF EVALUATIONS:	PHYSICAL:	SOCIAL:	PSYCHOLOGICAL:
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THIS INFORMATION MUST BE KEPT CONFIDENTIAL BY RECIPIENT	
CLIENT ELIGIBILITY DETERMINATION CRITERIA	
1.	DIAGNOSIS: <input type="checkbox"/> A. MENTAL RETARDATION <input type="checkbox"/> C. AUTISM <input type="checkbox"/> E. CEREBRAL PALSY <input type="checkbox"/> B. EPILEPSY <input type="checkbox"/> D. NEUROLOGICAL IMPAIRMENT <input type="checkbox"/> F. OTHER
2.	SEVERE BEHAVIOR PROBLEM: <input type="checkbox"/> Yes <input type="checkbox"/> No FREQUENCY: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Has occurred in the past 12 months
3.	HEALTH CARE NEED: A. Medical condition which requires daily individualized attention from health care staff <input type="checkbox"/> Yes <input type="checkbox"/> No B. Self injurious behavior which necessitates monitoring and treatment <input type="checkbox"/> Yes <input type="checkbox"/> No C. Deficit in self-care skills 1. No self-help skill <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Requires assistance and training in self performing self-care tasks. <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	ADAPTIVE BEHAVIOR DEFICIT: A. COMMUNICATION: 1. Individual has no expressive or receptive language <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Individual has some expressive or receptive language <input type="checkbox"/> Yes <input type="checkbox"/> No B. LEARNING: 1. I.Q. cannot be determined (certified untestable). <input type="checkbox"/> Yes <input type="checkbox"/> No 2. I.Q. of less than 50. <input type="checkbox"/> Yes <input type="checkbox"/> No 3. I.Q. of 50-69 <input type="checkbox"/> Yes <input type="checkbox"/> No C. MOBILITY: 1. Individual is non-ambulatory and totally dependent on others for moving from one place to another. <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Individual has some mobility skills but needs others assistance and training to increase his/her capacity for moving about. <input type="checkbox"/> Yes <input type="checkbox"/> No D. CAPACITY FOR INDEPENDENT LIVING: 1. Client is completely dependent on others for all household activities. <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Individual needs assistance or training to perform tasks to be contributing member of a household. <input type="checkbox"/> Yes <input type="checkbox"/> No E. SELF-DIRECTION: 1. Individual exhibits weekly misbehaviors requiring individualized programming. <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Individual is completely dependent on others for management of his/her personal affairs within the general community. <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Individual exhibits monthly misbehaviors requiring individualized programming. <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Individual needs assistance or training for management of his/her personal affairs within the general community. <input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> ICF/MR Level of Care Recommended for approval, effective for the period from ___ / ___ / ___ to ___ / ___ / ___		DATE OF ADMISSION:
<input type="checkbox"/> ICF/MR Level of Care NOT Recommended		
SIGNATURE OF REVIEW PHYSICIAN:		DATE:
HEALTH CARE INTEGRATION AGENCY REPRESENTATIVE NAME:	HEALTH CARE INTEGRATION AGENCY REPRESENTATIVE SIGNATURE: X	DATE:
HEALTH CARE INTEGRATION AGENCY NAME:		TITLE:
HEALTH CARE INTEGRATION AGENCY ADDRESS:	CITY:	STATE: ZIP CODE: