Client: Record Number:

Initial Level of Care Eligibility Determination
NC Innovations
☐ **Prior Approval** ☐ **Utilization Review**

Name _____
Last First Middle
Address_____
Date of Birth_____ Gender _____
County of Medicaid Eligibility _____
MID# _____Address_____
Legally Responsible/Guardian _____
Phone #_____
Address_____

1. Living in ICF-MR Facility ☐Yes ☐No

2. Diagnosed condition(s) that establish(es) the individual's developmental disability
Diagnosis:
☐ Intellectual Disability (IQ or % of Developmental Delay) _____
☐ Medical Condition: _____
☐ Related Condition: _____

Was the disability manifested prior to age 22?	☐Yes	■No
Is the disability likely to continue indefinitely?	☐Yes	☐No
Current substantial functional limitations: (Based on functional assessment)		
i. Self Care	☐Yes	☐No
ii. Understanding/Use of Language	☐Yes	☐No
iii. Learning	☐Yes	☐No
iv. Mobility	☐Yes	☐No
v. Self-direction	☐Yes	☐No
vi. Capacity for Independent Living	☐Yes	☐No
The individual could benefit from services and supports to promote the acquisition of skills, and to decrease or prevent regression.	☐ Yes	☐ No

6. **Level of Care Recommendation:**
☐ Eligible ICF-MR ☐ Not Eligible ICF-MR
Psychologist/Licensed Psychological Associate _____Date: _____
Physician _____ Date: _____

(MCO USE ONLY)
ICF/MR Level of Care Approved: _____Denied: _____
LOC Effective Date: _____
Prior Approval Number _____

_____
UM Clinical Care Manager/Signature/Date

_____
Medical Director Signature (if applicable) Date

NC MH/DD/SAS Health Plan
NC Innovations Waiver

Instructions for Level of Care Determination
This form is to be used for prior approval and utilization review of ICF-MR level of care.

Demographics

1. Name-Print last name, first name, middle initial. If no middle name or initial, use NMN.
2. Address-Enter the complete address where the person lives.
3. Date of Birth-Enter the month, day and year.
4. Gender-Enter a capital F to indicate Female or a capital M to indicate Male.
5. County of Medicaid Eligibility-List the county from which the person's Medicaid originates per the SIPPS system.
6. Medicaid Number-Enter the Medicaid Number assigned to the person.
7. Legally Responsible Person/Guardian-List the name of the person who is the legal guardian or responsible person for the individual who is being reviewed.
8. Address of Legally Responsible Person/Guardian-Enter the complete address where the Legal Guardian/Responsible person lives.

Living in ICF-MR facility

1. Place a check in the space indicating whether or not the person lives in an ICF-MR residential facility.

Diagnostic Information
Check all of the disability areas that apply based on the documented disability.

1. Check if the person has Mental Retardation/Intellectual Disability based on the documented assessment and document the IQ or the percentage of developmental delay.
2. Check if the person has a Medical Condition and list the condition based on the documented assessment. If no diagnosis, list NA.
3. Check if the person has a condition closely related to Mental Retardation based on the documented assessment and list the condition. If no diagnosis, list NA.
4. Check the appropriate box to address if the person could benefit from Skill Acquisition.

Was the Disability manifested before the age of 22?
Based on documented assessment, please check the correct box.
Is the disability likely to continue indefinitely?
Based on documented assessment, please check the correct box.
Current Substantial Functional Limitations
Place a check in the **Yes** box for each functional deficit the individual has based on documented assessment. If the individual does not have functional deficits in a specified area then check **No**.
Skill acquisition
Check the appropriate box to address if the person could benefit from Skill Acquisition.

Level of Care Certification
Based on assessment check the appropriate box to designate if the person meets the ICF-MR level of care. Get the Signature and Printed Name of a Licensed Psychologist/Psychological Associate or Physician as appropriate based on who completed the assessment.

Level of Care Recommendation

1. Based on review of information, check approved or denied for ICF-MR Level of Care
2. List the month/day/year that the Level of Care became effective
3. Document the Prior Approval Number
4. Get the signature of the UM Clinical Care Manager and date of signature
5. Get the signature of Medical Director and date of signature if needed.

NC INNOVATIONS MEDICAL ASSESSMENT

Individual's Name: _____ **Waiver:** _____

I. System Disorder/Name of Condition	**Circle One:**	
a. Respiratory	Yes	No
b. Cardiovascular	Yes	No
c. Gastro-Intestinal	Yes	No
d. Genito – Urinary	Yes	No
e. Neurological	Yes	No
f. Other	Yes	No

II. History of Seizures (Type)

Simple Partial (Simple motor movements/no awareness loss)	Yes	No
Complex Partial (Loss of Awareness)	Yes	No
Generalized – Absence (petit mal)	Yes	No
Controlled with medication	Yes	No

Other: _____
Seizure Frequency per month: _____

III. Disability

Cerebral Palsy	Yes	No
Mental Illness	Yes	No

Other Related Condition: _____

IV. Sensory/Motor Limitation

Hearing	Yes	No
Vision	Yes	No
Ambulatory	Yes	No
Fine Motor Deficit	Yes	No
Major Motor Deficit	Yes	No
Communication	Yes	No

V. Treatment Modality

Physical Therapy	Yes	No
Occupational Therapy	Yes	No
Speech Therapy	Yes	No
Special Diet Type: _____	Yes	No
Other: _____	Yes	No
(IV, Tube Feed, O2, Catheter, etc.) Supportive Protection Devices: _____	Yes	No

VI. Medications:

Individual can self medicate: Yes No

Medication	**Dosage/Route/Frequency**	**Related Diagnosis**

VII. Physician Signature

_____ _____ _____

Physician Name (Print) **Physician Signature** **Date**

Medication (Name)	Dosage/Route/Frequency	Related Diagnosis or Condition

Physician Orders:

To be Medicaid certified at the ICF-MR level-of-care, the individual must:

Require active treatment necessitating the ICF-MR level of care. (Active treatment refers to aggressive, consistent implementation of a program of specialized and generic training, treatment and health services. Active treatment does not include service to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.)

AND

Have a diagnosis of mental retardation, or a condition that is closely related to MR:

A. Mental retardation is a disability characterized by significant limitations both in intellectual functioning and adaptive behavior as expressed in conceptual, practical and social skills. The condition originates before the age of 18.

B. Persons with closely related conditions refer to individuals who have a severe, chronic disability that meets ALL of the following conditions:

1. Is attributable to:
   a. cerebral palsy or epilepsy or
   b. any other condition, other than mental illness, that is closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to mentally retarded persons;
2. It is manifested before the person reaches age 22;

3. Is likely to continue indefinitely; and

4. It results in substantial functional limitations in three or more of the following areas of major life activity:
   a. self-care (the ability to take care of basic life needs for food, hygiene, and appearance)
   b. understanding and use of language (the ability to both understand others and to express ideas or information to others either verbally or nonverbally)
   c. learning (the ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations)
   d. mobility (ambulatory, semi-ambulatory, non-ambulatory)
   e. self-direction (managing one's social and personal life and have the ability to make decisions necessary to protect one's self)
   f. capacity for independent living (age appropriate ability to live without extraordinary assistance)

Functional Limitations As Defined By Developmental Disabilities Act

The federal government has defined developmental disabilities as disabilities that are chronic and attributable to mental and/or physical impairments, which are evident prior to age twenty-two. Such disabilities tend to be lifelong and result in substantial limitations in three or more of the following major life activities:

a. Self-Care: Daily activities that enable a person to meet basic life needs for eating, hygiene, grooming, health and personal safety. A substantial limitation occurs when a person needs assistance at least one-half the time for one activity, or needs some assistance in more than one-half of all activities normally required for self-care. Assistance is usually in the form of the intervention of another person directly or indirectly by prompts, reminding and/or supervising someone.
b. Receptive and Expressive Language: Communication involving both verbal and nonverbal behaviors that enable the person both to understand others and to express ideas and information to others. The concept of language includes reading, writing, listening and speaking as well as the cognitive skills necessary for receptive language. A substantial limitation occurs when a person is unable to effectively communicate with another person without the aid of a third person, a person with a special skill, or a mechanical device, or is unable to articulate thoughts and/or to make ideas and wants known.
c. Learning: General cognitive competence and ability to acquire new behaviors, perceptions and information and to apply previous experience in new situations. When a person requires special intervention or special programs to assist that person in learning a substantial limitation occurs. Children who meet the eligibility standard for infant/toddler or special education services or need significant special interventions such as assistive devices or special testing procedures in regular education programs in order to learn would have a functional limitation in learning.
d. Mobility: Motor development and ability to use fine and gross motor skills. A substantial limitation occurs when the ability to use motor skills requires assistance of another person and/or a mechanical device in order for the person to perform age appropriate skills in two skill areas, or to move from place to place inside and/or outside the home.
e. Self-Direction: Ability to make independent decisions regarding and to manage and control one's social and individual activities and/or in handling personal finances and or protecting one's own self-interest. A substantial functional limitation occurs when a child is unable, at an age appropriate level, to make decisions and exercise judgment, behave in a socially acceptable manner, and/or act in his/her own interest. An adult may require direct or indirect assistance such as supervision by another person or counseling to successfully utilize these skills.
f. Capacity for Independent Living: Maintain a full and varied life in one's own home and community. A child who is unable, at an age appropriate level, to assist with household chores, maintain appropriate roles and relationships with the family, use money, and/or use community resources has a substantial functional limitation in this are. The child requires more assistance to perform these activities than a typical child of the same chronological age. An adult displays a significant functional limitation when he/she requires assistance in the activities more than half the time.