

# INSTRUCTIONS FOR ICF/MR LEVEL OF CARE DETERMINATION FORM

**NOTE:** Only Division of Developmental Disabilities TCM provider service coordinators have authority to evaluate ICF/MR level of care for the DD Waivers. The Regional Office must administratively approve all level of care evaluations and determinations of waiver eligibility.

1. **Initial Determination:** Place a check mark if this is the first time the person has been evaluated for ICF/MR level of care.

**Annual Redetermination:** Place a check mark if the person has been participating in the waiver and this is an annual redetermination (typically done in conjunction with the annual person centered plan).

**Other:** Place a check mark if this is not the initial or annual determination and note the reason for the new determination, i.e., significant change or align with individual service plan (ISP) date.

**Date of determination (date Service Coordinator completes form):** Before a person can become a waiver participant, the person must be initially determined to require ICF/MR level of care. Annually thereafter (within 12 months), the person must be reevaluated and a new ICF/MR level of care determination form must be completed to ensure the person remains eligible. The date of determination must be entered into the CIMOR Episode of Care, Assessment screen.

2. **Person:** Person's full name.
3. **DMH ID #:** Number assigned to the person by the regional office.
4. **Service Coordinator Signature/Other TCM Provider:** The individual who makes the determination that the person requires ICF/MR level of care must sign the form. If the form is completed by a service coordinator employed by another TCM provider, besides a regional office, that is approved to provide case management then the provider should be identified as well.
5. **Regional Office/Other TCM Provider:** Place a check mark in the appropriate box.
6. **I.A.1. Diagnoses:** This should be filled in with the most recently diagnosed conditions. Diagnoses should be in the ICD-9 format. Use diagnosis numbers, as there is no room to write out the diagnosis. If a person has so many diagnoses that they won't all fit on this form, please list the primary diagnoses which make the person eligible for services.

Federal rule defines 'Related Condition' as--

A severe, chronic disability which is attributable to cerebral palsy or epilepsy, or to any other condition, other than mental illness, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for such persons. In addition, the disability must have been manifested before the person reaches age 22, it is likely to continue indefinitely, and it results in substantial functional limitations in three or more of the following areas of major life activity: 1) Self-care 2) Understanding and use of language 3) Learning 4) Mobility 5) Self direction, and 6) Capacity for independent living.

7. **I.A.2. Life Activities:** Document the person has functional limitations in THREE (3) or more of the following areas of life activity or, if a child, has or is likely to have, functional limitations in at least three equivalent, age appropriate major life activities.

NOTE: *The differences between Missouri's statutory definition and the federal definition. The person must have functional limitations in THREE or more of the areas of life activity, rather than two. The federal definition does not include economic self-sufficiency as a major life activity; however, if the person has limitations in this area you may check "self care." Finally, the qualifying disability must be "other than mental illness."* To complete this part of the form you will need to check three or more of the limitations listed.

*If the person is a child, consider the age appropriateness of the child's abilities. There are three domains on the Vineland similar to the areas of federal limitations: communication, daily living skills and motor skills. Also, given the child's disability, consider his/her potential level of functioning in the areas of learning, self-direction and capacity for independent living. Attach any documentation (First Steps information, school assessments, etc.) that would describe limitations in other domains (behavior, socialization) not listed in this section. **If three (3) functional limitations are not noted, this individual IS NOT eligible for waived services.***

8. **I.B. Active Treatment:** Check yes or no. **If NO is checked, this individual IS NOT eligible for waived services.** Section I-B is intended to show that, if this person applied to enter an ICF/MR, he/she would have a need for active treatment and would therefore be eligible for ICF/MR placement. Filling out this section does NOT mean the person has to receive active treatment in these same areas if he/she enters the waiver.

**Functional Limitations:** Check any and all that apply. This area identifies more specific limitations than in Section I.A.2. above. If the person has limitations in addition to those mentioned here, describe the limitations in "other".

9. **II. ICF/MR Need:** Check yes or no. **If you check NO, this individual IS NOT eligible for the waiver.** What this question really means, and the context in which you should answer it is-- if there were no Home and Community Based Waiver, would this person need to go to an ICF/MR? Consider that, in the absence of the waiver, there would be many fewer group homes, ISLs, etc. around the state, and very many more ICFs/MR. Also, in the absence of a waiver, if the person couldn't continue to live in his current setting or if there were services the person needed but could not get in the community, there would be few, if any, alternatives to an ICF/MR.

**Summary of Determination:** Summarize your rationale for checking yes above. For example, you might consider that individuals with disabilities are usually supported by a network of family, friends, agencies etc....and that fully meeting an individual's needs might stress his/her support system to the breaking point, unless the waiver fills in or helps out. Then, if the individual had to make it by himself, would he be able to avoid placement? (Remember that in the absence of the waiver, his choices would be ICF/MR, RCF or Boarding Home. If he needs any habilitative services at all, his only choice would be the ICF/MR). Alternately, ask yourself, does this individual need services which, in the absence of the waiver, could only be provided in an ICF/MR? These could be services which the individual needs to gain for full potential. Again, consider that, without the waiver, the State would have had no choice but to pursue large scale ICF/MR development and the landscape of services for people with developmental disabilities would be very different from what it is now.

The scenarios above are only suggestions. You should tailor your response to the individual's situation. In addition to your rationale, you will need to indicate how waived services will prevent the person's needing to enter an ICF/MR and contribute to his or her being able to live in the community. Be succinct, but logically relate the services to providing a necessary and effective alternative to institutionalization.

**10. III. Assessment/Evaluations:** List all assessments completed (past and present) on which the determinations on this form were made. The MOCABI is the standard, baseline assessment for all waiver participants, except for children under age 18. There may be circumstances where the MOCABI may be appropriate for children age 17. For children, we recommend using the Vineland but other FORMAL assessments may be used (see list below). Additional assessments or sources of information may be IEPs, psychological, psychiatric evaluations, medical tests, behavioral and speech evaluations etc. Tests/evaluations must be performed by qualified professionals. If assessments are over 30 days old you must include a time that the information was reviewed and a statement regarding the continued accuracy of the information. (Example: Assessment type: MOCABI, Performed by: Sue Jones, Date: 7-1-2008, Date reviewed: 2-1-2009. This individual has not displayed significant changes in behavior, medical condition or level of functioning since this assessment was completed, therefore its results are still considered to be valid.”) People should be reassessed at least every other year which includes completing a new MOCABI, Vineland or other formal assessment for children. Once the evaluation is completed, the service coordinator must submit the form to the supervisor for review. The team supervisor is then responsible for entering the assessment into the CIMOR Episode of Care-Assessment section. The date of determination should be entered. If the consumer is eligible for the waiver, a score of 1 should be entered into the assessment screen. If the consumer is ineligible for the waiver a score of 0 should be entered and the reason for ineligibility must be entered into the Comments section of the assessment screen.

<b>Commonly Used Adaptive Behavior Devices</b>
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Adaptive Behavior Inventory (ABI)  
 Adaptive Behavior Assessment System-II (ABAS-II)  
 Adaptive Behavior Evaluation Scale (ABES-R)  
 Adaptive Behavior Rating Scale  
 Battelle Developmental Inventory (BDI)-2nd Edition  
 Bayley Scales of Infant Development - 2nd Edition  
 Child Development Inventory (CDI)  
 Comprehensive Test of Adaptive Behavior – Revised  
 Functional Evaluation for Assistive Technology (FEAT)  
 Normative Adaptive Behavior Checklist  
 Scales of Independent Behavior (SIB)  
 Street Skills Survival Questionnaire (SSSQ)  
 Vineland Adaptive Behavior Scales

**11. IV. Document Location:** Check where the assessments may be found. If results of all tests are in the regional office/other TCM provider file check “case record”. If some of them are in other locations (at a provider agency for instance) check “other location” and specify the type of evaluation and its location.

**12. Team Supervisor Approval Signature:** Each completed form must be submitted to a supervisor. Supervisors are to review form for completeness and enter into CIMOR database. Completeness indicates that all required fields are completed. Signature on this line indicates that the supervisor has approved the completed LOC assessment form and has entered the data into CIMOR.

**13. Regional Office Approval of Determination:** Forms completed by other TCM providers besides the regional office must be approved by regional office staff. Approval indicates that all information on the form is complete and based on the information provided on the form, the person is eligible for the waiver. As the operating agency for the waivers, DMH DD staff must approve LOC’s completed by TCM entities. For regional office service coordinators, Line 15 above constitutes regional office approval for the LOC.