

# **Forms and Instructions for Completion of the Level of Care Packet**

## **ICFMR Waiver Level of Care**

### **DIVISION OF COMMUNITY SERVICES**

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**35 East Chestnut Street, 5<sup>th</sup> Floor**

**Columbus, OH 43215-2541**

**614-752-9508**

**Included in this packet are the following forms and instructions:**

- ❖ **Initial Eligibility Determination**
- ❖ **Redetermination: No significant change in condition**
- ❖ **Redetermination: Significant change in condition**
- ❖ **Freedom of Choice Documentation**
- ❖ **Functional Assessments, by age group**

## **Instructions for the Completion of the Level of Care Packet**

- ❖ **Freedom of Choice Documentation**
- ❖ **Initial Eligibility Determination**
- ❖ **Redetermination: No significant change in condition**
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- ❖ **Functional Assessments, by age group**

### **Highlights of changes:**

- The 17-page assessment form is no longer required. The forms contained in this packet now substitute for the previous 17-page assessment form.
- A physician's signature and a psychologist's signature is now required only to establish the diagnosed condition for the initial eligibility determination or whenever there is a significant change of condition and is not required on the Level of Care form.
- The county board of MR/DD makes a recommendation as to whether the individual meets the criteria for an ICF/MR Level of Care.
- The Ohio Department of MR/DD, as designee of the Ohio Department of Job and Family Services, makes the determination of the individual's Level of Care.
- The Ohio Department of Job and Family Services reviews a sample of Level of Care determinations for quality control purposes.

### **General instructions:**

- Use the attached forms for initial and redetermination requests for the Individual Options and Residential Facility Waivers
  
- Do not use these forms for enrollment on the Ohio Home Care Waiver, which is administered by the Department of Job & Family Services, or the PASSPORT Waiver, which is administered by the Department of Aging, or for ICFMR facility Level of Care, which has a separate process.
  
- Complete all fields as described in these instructions. Do not leave a field blank. Place an N/A (non-applicable) in a field that does not apply.
  
- Use black or blue ink to complete the forms, or type. Do not use correction fluid or correction tape to make corrections. Make corrections by drawing a single line through the mistake, add the correct information and initial the change. You may reproduce the forms in exact form for computer use. On request, the Office of Community Medicaid Services will provide a Word version of each of the forms.
  
- Send original forms, except the Freedom of Choice Form, to the Office of Community Medicaid Services. Keep the original Freedom of Choice Form and include a copy in the packet. Forms must be mailed, not faxed or emailed. Mail to:  
Ohio Department of MRDD  
Community Medicaid Services, Waiver Unit  
35 East Chestnut Street, 5<sup>th</sup> Floor  
Columbus, OH 43215-2541
  
- Keep a copy of the packet in the county board's official waiver file, so that it is available for ODMR/DD review by the Division of Audits, Facility Licensure/Quality Assurance and/or Office of Accreditation, and by ODJFS Quality Assurance and Audits.

## Initial Level of Care Eligibility Determination

Use this form when completing a Level of Care packet for an individual who is not already receiving HCBS Waiver services through the Department of MR/DD. If the individual has been receiving Home Care Waiver services or Passport Waiver services, treat the application as an initial eligibility determination.

### APPLICANT INFORMATION block

Name	Enter the first name, middle initial and last name of the individual applying for waiver services. Use the individual's given name as it appears on legal documents, not a nickname.
Date of Birth	Enter the month, day and year of the applicant's date of birth, in mm/dd/yyyy format.
County	Enter the county board that will be responsible for the delivery of HCBS waiver services, even if a council of government (COG) administers the waiver.
Social Security Number	Enter the enrollee's 9-digit Social Security Number.
Address	Enter the street address, city and zip code where the individual will reside when enrolled on the waiver.
Guardian	Enter the name of the individual's guardian, if the individual has a court-appointed legal guardian. If not, write "N/A".
[Guardian's] Address	Enter the street address, city and zip code of the individual's legal guardian, if the individual has a guardian. Otherwise, leave blank.
Residence when enrolled	Check the box for the type of setting in which the applicant will live, once HCBS waiver services begin. If "group home" is marked, please indicate the facility number from the Index to Licensed Facilities. If "other" is marked, please indicate the type of residence.
Is the applicant currently receiving residential, supported living, or waiver services?	<ol style="list-style-type: none"> <li>1. Circle Yes if the individual lives in a group home or ICF/MR.</li> <li>2. Circle Yes if the individual lives in any setting and receives services and supports financed with state or local supported living dollars.</li> <li>3. Circle Yes if the individual currently receives Individual Options Waiver services or Residential Facility Waiver services and is changing to a different type of HCBS waiver administered by ODMR/DD.</li> <li>4. Circle No if the individual does not meet conditions 1-3.</li> </ol>
Waiver request	Check the box for the waiver for which the individual is applying. Check only one box.
Priority status	Check the box to indicate the individual's priority status, per the waiting list priorities in ORC 5126.042. See attachment A for a description of priority groups.
Waiver Enrollment Number (slot/control number)	Check the box to indicate the status of the Waiver Enrollment Number (slot/control number) the individual will use. If the applicant is replacing an individual who has been disenrolled, indicate the name of the disenrolled individual, the waiver enrollment number that the disenrolled individual occupied, and the last date of waiver service received by that individual.

## ICF/MR WAIVER LEVEL OF CARE block

<p>1. Protective Level of Care OAC 5101:3-3-08 and 5101:3-3-07(C)(1)</p>	<p>Circle Yes or No to indicate whether the individual meets Protective Level of Care. The individual must meet the minimum criteria for Protective Level of Care as defined in Attachment B.</p>
<p>2a. Diagnosed condition that establishes the individual's developmental disability, age 6 and above OAC 5101: 3-3-07(C)(2)</p>	<p>Enter the diagnosed condition that establishes the individual's developmental disability. Indicate all conditions that apply.</p> <ul style="list-style-type: none"> <li>○ If "mental retardation" is indicated, the individual must have mild, moderate, severe or profound mental retardation.</li> <li>○ Attach a medical evaluation completed by a licensed physician <b>and</b> either a psychological evaluation signed by a licensed psychologist or a psychiatric evaluation signed by a licensed psychiatrist that verify the individual's diagnosed condition. An evaluation is any properly signed statement that establishes the diagnosed condition and date of onset.</li> <li>○ The diagnosis and date of onset is critical to establish the developmental disability.</li> </ul>
<p>2b. Developmental delays assessed for individuals birth through age five</p>	<ul style="list-style-type: none"> <li>○ Indicate all developmental delays that assessments have identified for this individual, only for individuals from birth through age 5.</li> </ul>
<p>3. Manifested before 22? OAC 5101:3-3-07(C)(3)</p>	<ul style="list-style-type: none"> <li>○ Circle Yes or No to indicate whether the disability was manifested before the age of 22.</li> </ul>
<p>4. Continue indefinitely? OAC 5101:3-3-07(C)(4)</p>	<ul style="list-style-type: none"> <li>○ Circle Yes or No to indicate whether the disability is likely to continue indefinitely.</li> </ul>
<p>5. Substantial functional limitations OAC 5101:3-3-07(C)(5)</p>	<p>Circle 'yes' or 'no' for each of the seven questions in this section. Base these answers on a completed functional assessment, as found in Attachments C through F. Use the correct functional assessment for the individual's age group. Keep the functional assessment on file. Do not submit the assessment form.</p>
<p>6-7. Skill acquisition OAC 5101:3-3-07(C)(6) and (C)(7)</p>	<p>Skill acquisition means the individual could benefit from services and supports specifically designed to promote the individual's acquisition of skills and decrease or prevent regression in the performance of those major life activities where substantial functional limitations have been identified. Circle yes or no to indicate whether the individual could benefit from services and supports to promote the acquisition of skills in each area of substantial functional limitation marked in item 5 above and is willing to participate in an individualized plan of services and supports.</p>
<p>8. Level of Care Recommendation</p>	<p>The Service Support Administrator must check a box to indicate which Level of Care is recommended for the individual. The Service and Support Administrator must sign and date the recommendation and provide his/her title.</p>
<p>9. Proposed Date for Waiver Services to Begin</p>	<p>Indicate the month, day and year the county board wants waiver services to begin. The Office of Community Medicaid Services will attempt to honor this request date, but there is no guarantee that it will be the actual date set. In no case will the level of care effective date be prior to the date that a completed ICF/MR Level of Care Eligibility Determination Form' is received by the Office of Community Medicaid Services.</p>

**Redetermination: No significant change in condition**

Use this form when completing a Level of Care packet for an individual who is already receiving HCBS Waiver services through the Department of MR/DD and whose condition has not changed to the extent that a different Level of Care could be warranted..

**APPLICANT INFORMATION block**

Name	Enter the first name, middle initial and last name of the individual applying for waiver services. Use the individual’s given name as it appears on legal documents, not a nickname.
County	Enter the county board that will be responsible for the delivery of HCBS waiver services, even if a council of government (COG) administers the waiver.
Date of Birth	Enter the month, day and year of the applicant’s date of birth, in mm/dd/yyyy format.
Social Security Number	Enter the enrollee’s 9-digit Social Security Number.
Address	Enter the street address, city and zip code the individual will reside at when enrolled on the waiver.
Guardian	Enter the name of the individual’s guardian, if the individual has a court-appointed legal guardian. If not, write “N/A”.
[Guardian’s] Address	Enter the street address, city and zip code of the individual’s legal guardian, if the individual has a guardian. Otherwise, write N/A.
Waiver Enrollment Number	Enter the waiver enrollment number (slot/control number) the individual uses.
Current residence	Check the box for the type of setting in which the applicant lives. If “group home” is marked, please indicate the facility number from the Index to Licensed Facilities. If “other” is marked, please indicate the type of residence.
Waiver type	Check the box to indicate the type of waiver for which the individual is reapplying.

**ICF/MR LEVEL OF CARE block**

Level of Care Effective Date	Indicate the month, day and year the county board of mrdd wants renewed waiver services to begin. The Office of Community Medicaid Services will make every effort to honor this request date, but there is no guarantee that it will be the actual date set. In no case will the level of care effective date be set prior to the date that a completed ICF/MR Level of Care Eligibility Determination Form’ is received by the Office of Community Medicaid Services.
Span Date	Indicate the span date for waiver services.
Certification of continuing Level of Care	The signature of the Service and Support Administrator indicates that there has been no significant change in the individual’s condition that would possibly lead to a determination of a different Level of Care. The Service and Support Administrator must date this signature and provide his/her title.

## Redetermination: Significant change in condition

Use this form when completing a Level of Care packet for an individual who is already receiving HCBS Waiver services through the Department of MR/DD. Use this form instead of “Redetermination: No significant change in condition” when the individual’s physical or mental condition, or functional abilities change to an extent that there is some question about whether the individual’s Level of Care may have changed.

### APPLICANT INFORMATION block

Name	Enter the first name, middle initial and last name of the individual applying for waiver services. Use the individual’s given name as it appears on legal documents, not a nickname.
County	Enter the county board that will be responsible for the delivery of HCBS waiver services, even if a council of government (COG) administers the waiver.
Date of Birth	Enter the month, day and year of the applicant’s date of birth, in mm/dd/yyyy format.
Social Security Number	Enter the enrollee’s 9-digit Social Security Number. If the applicant does not have a Social Security Number, write NONE in the blank.
Address	Enter the street address, city and zip code of the individual’s current residence.
Guardian	Enter the name of the individual’s guardian, if the individual has a court-appointed legal guardian. If not, write “none”.
[Guardian’s] Address	Enter the street address, city and zip code of the individual’s legal guardian, if the individual has a guardian. Otherwise, leave blank.
Waiver Enrollment Number	Enter the waiver enrollment number (slot/control number) the individual uses.
Current residence	Check the box for the type of setting in which the applicant lives. If “group home” is marked, please indicate the facility number from the Index to Licensed Facilities. If “other” is marked, please indicate the type of residence.
Waiver type	Check the box to indicate the type of waiver for which the individual is reapplying.

## ICF/MR WAIVER LEVEL OF CARE block

<p>1. Protective Level of Care OAC 5101:3-3-08 and 5101:3-3-07(C)(1)</p>	<p>Circle Yes or No to indicate whether the individual meetings Protective Level of Care. The individual must meet the minimum criteria for Protective Level of Care as defined in Attachment A.</p>
<p>2a. Diagnosed condition that establishes the individual's developmental disability, age 6 and above OAC 5101: 3-3-07(C)(2)</p>	<p>Enter the diagnosed condition that establishes the individual's developmental disability. Indicate all conditions that apply.</p> <ul style="list-style-type: none"> <li>○ If "mental retardation" is indicated, the individual must have mild, moderate, severe or profound mental retardation.</li> <li>○ Attach a medical evaluation completed by a licensed physician <b>and</b> either a psychological evaluation signed by a licensed psychologist or a psychiatric evaluation signed by a licensed psychiatrist that verify the individual's diagnosed condition. An evaluation is any properly signed statement that establishes the diagnosed condition and date of onset.</li> <li>○ The diagnosis and date of onset is critical to establish the developmental disability.</li> </ul>
<p>2b. Developmental delays assessed for individuals birth through age five</p>	<ul style="list-style-type: none"> <li>○ Indicate all developmental delays that assessments have identified for this individual, only for individuals from birth through age 5.</li> </ul>
<p>3. Manifested before 22? OAC 5101:3-3-07(C)(3) 4. Continue indefinitely? OAC 5101:3-3-07(C)(4)</p>	<ul style="list-style-type: none"> <li>○ Circle Yes or No to indicate whether the disability was manifested before the age of 22.</li> <li>○ Circle Yes or No to indicate whether the disability is likely to continue indefinitely.</li> </ul>
<p>5. Substantial functional limitations OAC 5101:3-3-07(C)(5)</p>	<p>Circle 'yes' or 'no' for each of the seven questions in this section. For the criteria for each area of life activity, refer to Attachments C through F, functional assessments.</p>
<p>6-7. Skill acquisition OAC 5101:3-3-07(C)(6) and (C)(7)</p>	<p>Skill acquisition means the individual could benefit from services and supports specifically designed to promote the individual's acquisition of skills and decrease or prevent regression in the performance of those major life activities where substantial functional limitations have been identified. Circle yes or no to identify if the individual could benefit from services and supports to promote the acquisition of skills in each area of substantial functional limitation marked in item 5 above and is willing to participate in an individualized plan of services and supports.</p>
<p>8. Level of Care Recommendation</p>	<ul style="list-style-type: none"> <li>❖ The Service Support Administrator must check a box to indicate which Level of Care is recommended for the individual.</li> <li>❖ Indicate the month, day and year the county board of mrdd wants renewed waiver services to begin. The Office of Community Medicaid Services will make every effort to honor this request date, but there is no guarantee that it will be the actual date set. In no case will the level of care effective date be set prior to the date that a completed ICF/MR Level of Care Eligibility Determination Form' is received by the Office of Community Medicaid Services.</li> <li>❖ Indicate the span date for waiver services.</li> <li>❖ The Service and Support Administrator must sign and date the recommendation and provide his/her title.</li> </ul>

## Freedom of Choice Documentation

Complete this form for all waiver applicants, whether seeking initial waiver enrollment or redetermination of eligibility. Send a copy of the Freedom of Choice Documentation form with the waiver packet, both at initial eligibility determination and at redetermination.

A. Selection of HCBS Waiver	Check the appropriate box.
B. Applicant Responsibilities	Review each item with the applicant.
Signature boxes	Obtain the signature and date for the applicant and/or authorized representative and/or legal guardian and the Service and Support Administrator.

Q: What if the individual does not choose HCBS Waiver services?

A: If an individual does not choose HCBS Waiver Services, do not send the form to the Department, as there will not be a Waiver Application submitted. Place the form in the applicant's file at the county board.

## Required Evaluations

The process for determining ICF/MR Level of Care is found in OAC 5101:3-3-155. Specifically, the rule states evaluations must include:

- (a) Diagnosis, including medical, psychiatric and developmental diagnoses, including dates of onset, if the date of onset is significant in determining whether the individual has a developmental disability; and
- (b) Review of current functional capacity.

Evaluation of the individual's current functional capacity and any other pertinent evaluations should be maintained in the individual's file by the home county. Only documentation of diagnosis must be submitted with the initial ICF/MR Waiver Level of Care packet.

## Functional Assessments

The Functional Assessments contained in this packet reflect the ICF/MR Level of Care criteria for waiver services, found in OAC 5101: 3-3-07. This rule specifies that each individual must have three limitations of the possible seven major areas of life activity (six for children) to qualify for ICF/MR Level of Care. Each Functional Assessment lists the areas of life activity and gives the criteria for determining whether an individual has a functional limitation in the life area. Because the criteria are specific to the individual's age group, a different Functional Assessment applies to each age group. The Functional Assessments included in this packet are required for those who conduct assessments for the purpose of establishing ICF/MR Level of Care for waiver services.