DODD Redetermination: Significant Change

APPLICANT INFORMATION

Name _____ **County** _____ **DODD #** _____
Date of Birth _____ **Social Security #** _____
Household Mailing Address _____

Guardian _____ **Address** _____

Waiver Type (check one) ☐Individual Options ☐Level 1 ☐SELF (☐Child or ☐Adult) ☐TDD

ICF/MR LEVEL OF CARE: Redetermination

1a.TDD Enter PEAT Date Only: **(skip to section 9 of the initial application)**

1b. The individual meets the minimum criteria for Protective Level of Care ☐**Yes** ☐**No**

2a.Diagnosed condition(s) that establish(es) the individual's developmental disability (age 6 and above) ____
_____
Attach a medical evaluation and a psychological/psychiatric evaluation that verify this diagnosed condition

2b.Developmental delays assessed for individuals birth through age five _____
_____
***Adaptive Behavior / Physical development or maturation, fine and gross motor skills, growth / Cognition / Communication / Social or Emotional Development / Sensory Development (5101:3-3-07)**

3. Was the disability manifested prior to age 22? ☐Yes ☐No
4. Is the disability likely to continue indefinitely? ☐Yes ☐No

5. Current substantial functional limitations: Can the individual perform the task independently, safely, consistently, without undue effort and in a reasonable time? (Based on functional assessment) Refer to OAC 5101:3-3-07

i. 3 developmental delays (birth to age 5 only)	☐ N/A	☐ Yes	☐ No
ii. Capacity for Independent Living (age 6+)		☐ Yes	☐ No
iii. Communication (age 6+)		☐ Yes	☐ No
iv. Learning (age 6+)		☐ Yes	☐ No
v. Mobility (age 6+)		☐ Yes	☐ No
vi. Personal Care (age 6+)		☐ Yes	☐ No
vii. Self-direction (age 6+)		☐ Yes	☐ No
viii. Economic Self-Sufficiency (age 16+ only)	☐ N/A	☐ Yes	☐ No

6-7. Skill Acquisition: The individual could benefit from services and supports to promote the acquisition of skills and to decrease or prevent regression in the performance in areas where delays are indicated and agrees to participate in an individualized plan of services and supports. ☐Yes ☐No

8. Level of Care Recommendation: ICF/IID : ☐Yes ☐No

9. Proposed Waiver Begin Date: _____
Name: (Please print) _____**Title:** _____
SSA Signature: _____ **Date:** _____

(DODD USE ONLY)
ICF/IID Level of Care Approved: ☐ Denied: ☐

QMRP Signature _____

Date of LOC Determination _____
LOC DENIAL REVIEW:
QMRP Manager Review Approved: ☐ Denied: ☐
Signature/Date _____

DODD REDET SIG. CHANGE 0512

Application Denied or Withdrawn for other reason: ☐

Explanation: _____

Waiver Begin Date: _____

Application Review:

Signature/Date_____