

**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/IID LEVEL OF CARE: Redetermination**

1. The individual meets the minimum criteria for Protective Level of Care		<input type="checkbox"/> Yes <input type="checkbox"/> No
2a. Diagnosed condition(s) that establish(es) the individual's developmental disability (age 6 and above) _____		
<b>Attach a medical evaluation and a psychological/psychiatric evaluation that verify this diagnosed condition</b> _____		
2b. Developmental delays assessed for individuals birth through age five _____		
<b>*Adaptive Behavior / Physical development or maturation, fine and gross motor skills, growth / Cognition / Communication / Social or Emotional Development / Sensory Development (5101:3-3-07)</b>		
3. Was the disability manifested prior to age 22?		<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is the disability likely to continue indefinitely?		<input type="checkbox"/> Yes <input type="checkbox"/> 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)	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
ii. Capacity for Independent Living (age 6+)		<input type="checkbox"/> Yes <input type="checkbox"/> No
iii. Communication (age 6+)		<input type="checkbox"/> Yes <input type="checkbox"/> No
iv. Learning (age 6+)		<input type="checkbox"/> Yes <input type="checkbox"/> No
v. Mobility (age 6+)		<input type="checkbox"/> Yes <input type="checkbox"/> No
vi. Personal Care (age 6+)		<input type="checkbox"/> Yes <input type="checkbox"/> No
vii. Self-direction (age 6+)		<input type="checkbox"/> Yes <input type="checkbox"/> No
viii. Economic Self-Sufficiency (age 16+ only)	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> 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.		<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Level of Care Recommendation:    ICF/IID :		<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Proposed Waiver Begin Date: _____		
Name: (Please print) _____ Title: _____		
SSA Signature: _____ Date: _____		

<p><b>(DODD USE ONLY)</b>                  ICF/IID Level of Care    Approved: <input type="checkbox"/>    Denied: <input type="checkbox"/>                   QMRP Signature _____                   Date of LOC Determination _____  <b>LOC DENIAL REVIEW:</b>                  QMRP Manager Review    Approved: <input type="checkbox"/>    Denied: <input type="checkbox"/>                  Signature/Date _____</p>	<p><b>Application Denied or Withdrawn for other reason:</b>    <input type="checkbox"/>                   Explanation: _____                   Waiver Begin Date: _____                   Application Review:                  Signature/Date _____</p>
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