

DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

MARYLAND
MEDICAL ASSISTANCE
PROGRAM

HOME AND COMMUNITY-BASED
SERVICES WAIVER FOR
CHILDREN WITH AUTISM

Determination of Eligibility for Level of Care in an Intermediate Care Facility for
the Mentally Retarded and Persons with Related Conditions (ICF-MR)

Full Name of Waiver Applicant/ Participant: _____
First Middle Last

LEA or LLA: _____

____ Initial Determination or ____ Re-determination Date of Birth _____

		Client Functional Capacity (Level of Impairment)					Client Functioning Use this space to briefly justify need for level of support. (Comments, if needed.)	Intensity of Support					
		Independent	Mild	Moderate	Severe	Profound		None	Consultation, Cues	Intermittent w/ky	Intermittent daily	Supervision > 50%	1:1 Supervision 100%
Basic ADLs (Activities of Daily Living)	Eating	0	1	2	3	4		0	1	2	3	4	5
	Toileting-bladder	0	1	2	3	4		0	1	2	3	4	5
	Toileting-bowel	0	1	2	3	4		0	1	2	3	4	5
	Mobility/transferring	0	1	2	3	4		0	1	2	3	4	5
	Hygiene/grooming	0	1	2	3	4		0	1	2	3	4	5
	Bathing	0	1	2	3	4		0	1	2	3	4	5
	Dressing	0	1	2	3	4		0	1	2	3	4	5
	Other self-care	0	1	2	3	4		0	1	2	3	4	5
TOTAL													
Functional ADLs	Able to bond	0	1	2	3	4		0	1	2	3	4	5
	Able to learn	0	1	2	3	4		0	1	2	3	4	5
	Accepts change	0	1	2	3	4		0	1	2	3	4	5
	Attention span	0	1	2	3	4		0	1	2	3	4	5
	Aware of needs	0	1	2	3	4		0	1	2	3	4	5
	Community participation	0	1	2	3	4		0	1	2	3	4	5

		Client Functional Capacity <i>(Level of Impairment)</i>					Client Functioning Use this space to briefly justify need for level of support. (Comments, if needed.)	Intensity of Support					
		Independent	Mild	Moderate	Severe	Profound		None	Consultation/ Cues	Intermittent w/ky	Intermittent daily	Supervision > 50%	1:1 Supervision 100%
Functional ADLs (Psychological and Developmental Activities of Daily Living)	Fine motor skills	0	1	2	3	4		0	1	2	3	4	5
	Follows simple familiar commands	0	1	2	3	4		0	1	2	3	4	5
	Gross motor skills	0	1	2	3	4		0	1	2	3	4	5
	Hand/eye coordination	0	1	2	3	4		0	1	2	3	4	5
	Imitates others	0	1	2	3	4		0	1	2	3	4	5
	Initiates social interaction	0	1	2	3	4		0	1	2	3	4	5
	Interest in others	0	1	2	3	4		0	1	2	3	4	5
	Judgment/ decision making	0	1	2	3	4		0	1	2	3	4	5
	Mobility/community	0	1	2	3	4		0	1	2	3	4	5
	Plays appropriately	0	1	2	3	4		0	1	2	3	4	5
	Plays imaginatively	0	1	2	3	4		0	1	2	3	4	5
	Receptive communication	0	1	2	3	4		0	1	2	3	4	5
	Self-direction	0	1	2	3	4		0	1	2	3	4	5
	Understands danger	0	1	2	3	4		0	1	2	3	4	5
	Other (Describe)	0	1	2	3	4		0	1	2	3	4	5
TOTAL													

Determination of Eligibility for Level of Care in an Intermediate Care Facility for the Mentally Retarded and Persons with Related Conditions (ICF-MR)

**DEPARTMENT OF HEALTH
AND MENTAL HYGIENE**

**MARYLAND MEDICAL
ASSISTANCE PROGRAM**

Name of Waiver Applicant or Participant: _____
First Last

Developmental Disability Diagnosis: 299.00 Autistic Disorder
(Check one) 299.80 PDD,NOS (Atypical Autism)

Describe each of the following:

History	Medications	
	Frequent medical care	
	Hospitalizations	
	Living Environment	
	Police/Court involvement	
	Social Services involvement	
	Supervision Requirement	
	Other significant history/ diagnoses	

Current Services:	Aide	<input type="checkbox"/>	Medical Management	<input type="checkbox"/>	Respite Care	<input type="checkbox"/>
	Alternative Therapies	<input type="checkbox"/>	Mental Health Services	<input type="checkbox"/>	Social Work Services	<input type="checkbox"/>
	Day Care	<input type="checkbox"/>	Nursing	<input type="checkbox"/>	Special Education <20 hrs/wk	<input type="checkbox"/>
	Dietary Support	<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>	Special Education ≥20hrs/wk	<input type="checkbox"/>
	Early Intervention Services	<input type="checkbox"/>	Physical Therapy	<input type="checkbox"/>	Speech/Language Therapy	<input type="checkbox"/>
	Extended Day (Special Ed)	<input type="checkbox"/>	Preschool	<input type="checkbox"/>	Supported Employment	<input type="checkbox"/>
	Extended Year Services	<input type="checkbox"/>	Preschool (Special Ed)	<input type="checkbox"/>	Vocational Education/DORS	<input type="checkbox"/>
	Head Start	<input type="checkbox"/>	Prevoc/vocational Svcs	<input type="checkbox"/>	Other _____	<input type="checkbox"/>
	Home Health Svcs.	<input type="checkbox"/>				

Determination of Eligibility for Level of Care in an Intermediate Care Facility for the Mentally Retarded and Persons with Related Conditions (ICF-MR)

Applicant or participant is assessed as developmentally disabled by meeting all of the requirements in (a) - (d) below, as required by CFR §435.1009 for **persons with related conditions**:

individuals who have a severe, chronic disability that meets all of the following conditions:

(a) It is attributable to--

(1) *Cerebral palsy or epilepsy, or*

(2) *Any other condition [such as autism], other than mental illness, found to be closely related to mental retardation because this 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 these persons;*

(b) *It is manifested before the person reaches age 22;*

(c) *It is likely to continue indefinitely; and*

(d) *It results in substantial functional limitations in the areas of major life activities (as described on pages 1 - 4 of this evaluation. See final page of instructions for further explanation).*

An institution for the Mentally Retarded and Persons with Related Conditions (ICF-MR) is defined in CFR§435.1009 as being: an institution (or distinct part of an institution) that--

(a) *Is primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions; and*

(b) *Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.*

Applicant or participant needs a continuous active treatment program, which is defined in CFR§483.440 to include aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward--

(i) *The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and*

(ii) *The prevention or deceleration of regression or loss of current optimal functional status.*

Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

Determination	_____ Applicant's Name (First and Last)	<p align="center">TOTAL SCORES of THREE DOMAINS</p> <p>Basic ADLs (min=24) _____</p> <p>Functional ADLs (min=63) _____</p> <p>Maladaptive Behaviors (min=54) _____</p>
	_____ is certified for the level of care in an Intermediate Care Facility for the Mentally Retarded and Persons with Related Conditions (ICF-MR) by meeting all requirements for that determination. _____ is not certified for the level of care in an Intermediate Care Facility for the Mentally Retarded and Persons with Related Conditions (ICF-MR). Explanation:	
Signatures	<input type="checkbox"/> Licensed Psychologist or <input type="checkbox"/> Certified School Psychologist on Multidisciplinary Team:	
	Name _____ (Please Print, First and Last)	Signature _____ Date Signed _____
Chair of the Multidisciplinary Team:		
Name _____ (Please Print, First and Last)	Signature _____ Date Signed _____	