



STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

HCBS Form 02.02.97 (5/2010, 4/2011)
Form URAC-2 (4-86)

ICF/MR-LEVEL OF CARE ELIGIBILITY DETERMINATION (LCED) FORM

Please refer to the accompanying instructions for information on completing this form.

Name of Individual			
Address		D.O.B.	Status: 620 / 621
Responsible Medicaid District		Medicaid No (CIN)	TABS ID
Dates of Pre-enrollment Evaluations:	Physical	Social	Psychological
<i>This information must be kept confidential by recipient</i> ELIGIBILITY DETERMINATION CRITERIA			
1. DIAGNOSIS: A. Mental Retardation <input type="checkbox"/> B. Epilepsy <input type="checkbox"/> C. Autism <input type="checkbox"/> D. Neurological impairment <input type="checkbox"/> E. Cerebral Palsy <input type="checkbox"/> F. Familial Dysautonomia <input type="checkbox"/> G. Other <input type="checkbox"/> (specify:)			
2. DISABILITY MANIFESTED PRIOR TO AGE 22: YES <input type="checkbox"/> NO <input type="checkbox"/>		3. SEVERE BEHAVIOR PROBLEM: YES <input type="checkbox"/> NO <input type="checkbox"/> A. Daily <input type="checkbox"/> B. Weekly <input type="checkbox"/> C. Monthly <input type="checkbox"/> D. Occurred in past 12 months <input type="checkbox"/>	
4. HEALTH CARE NEED: YES <input type="checkbox"/> NO <input type="checkbox"/>			
A. Individual has a medical condition which requires daily individualized attention from health care staff		YES <input type="checkbox"/>	NO <input type="checkbox"/>
B. Individual displays self-injurious behavior which necessitates monitoring and treatment		YES <input type="checkbox"/>	NO <input type="checkbox"/>
C. Individual has deficits in self-care skills		YES <input type="checkbox"/>	NO <input type="checkbox"/>
1. Extremely limited self-help skills, requires total assistance with self-care tasks		YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Demonstrates some self-help skills, but requires assistance and training in performing self-care tasks		YES <input type="checkbox"/>	NO <input type="checkbox"/>
5. ADAPTIVE BEHAVIOR DEFICIT: YES <input type="checkbox"/> NO <input type="checkbox"/>			
A. COMMUNICATION: YES <input type="checkbox"/> NO <input type="checkbox"/>			
1. Individual has extremely limited expressive or receptive language skills		YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Individual has some expressive or receptive language but requires assistance to communicate needs		YES <input type="checkbox"/>	NO <input type="checkbox"/>
B. LEARNING: YES <input type="checkbox"/> NO <input type="checkbox"/>			
1. I.Q. score cannot be determined using standardized test measures (certified untestable)		YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. I.Q. score of less than 50		YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. Over 21 years of age, person's reading and computation skills are at first grade level or below		YES <input type="checkbox"/>	NO <input type="checkbox"/>
4. I.Q. score of 50 – 69		YES <input type="checkbox"/>	NO <input type="checkbox"/>
5. Over 21 years of age, person's reading and computational skills are at third grade level or below		YES <input type="checkbox"/>	NO <input type="checkbox"/>
C. MOBILITY: YES <input type="checkbox"/> NO <input type="checkbox"/>			
1. Individual is non-ambulatory and totally dependent on staff for moving from one place to another		YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Individual has some mobility skills but needs staff assistance and training to increase his/her capacity for moving about		YES <input type="checkbox"/>	NO <input type="checkbox"/>
D. CAPACITY FOR INDEPENDENT LIVING: YES <input type="checkbox"/> NO <input type="checkbox"/>			
1. Individual is completely dependent on others for all household activities		YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Individual needs assistance or training to perform tasks to be a contributing member of household		YES <input type="checkbox"/>	NO <input type="checkbox"/>
E. SELF-DIRECTION: YES <input type="checkbox"/> NO <input type="checkbox"/>			
1. Individual exhibits frequent (i.e., weekly) challenging behaviors requiring individualized programming		YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Individual is completely dependent on others for management of his/her personal affairs within the general community		YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. Individual exhibits episodic (i.e., monthly) challenging behaviors requiring individualized programming		YES <input type="checkbox"/>	NO <input type="checkbox"/>
4. Individual needs assistance or training for management of his/her personal affairs within the general community		YES <input type="checkbox"/>	NO <input type="checkbox"/>

See next page for required signatures.



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Name of Individual:	Medicaid No (CIN):
Signature of Qualified Person Completing the Form	Review Date
Signature of Review Physician	Review Date

This section to be completed by the DDSO Director (or Designee) for initial LCED determinations only		
Has the OPWDD process for DD Eligibility been completed by the DDSO?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<input type="checkbox"/> ICF/MR Level of Care Approved Effective (mm/dd/yy):	<input type="checkbox"/> ICF/MR Level of Care NOT Approved	
Date of Waiver Enrollment (mm/dd/yy):		
Signature of DDSO Director (or Designee):	Date (mm/dd/yy):	

Annual ICF/MR Level of Care Eligibility (LCED) Redetermination

The annual LCED redetermination must be reviewed within 365 days from the last review date or the effective date in the field "ICF/MR Level of Care Approved Effective (mm/dd/yy)" above.

By signing below, I affirm that based upon my knowledge of the individual and a review of the most recent psychological evaluation, social evaluation/history, medical history, and the information outlined in questions 1-5, that there has been no significant change that impacts this individual's eligibility for ICR/MR level of care. The LCED is redetermined to be effective for one year (i.e., 365 days) from the signature date below.

Signature and Title of Qualified Person Completing the Form	Review Date

Note: If an individual no longer meets the ICF/MR level of care, the DDSO must immediately be contacted for further action.