

ICF/MR LEVEL OF CARE EVALUATION

Alabama Department of MH/MR

Applicant Name _____

Medicaid Number _____ LAH MR/DD

Facility _____

Program Name _____ Program/Site Number _____

Intermediate Care Services are those services which are needed because of the severe, chronic nature of the mental impairment that results in substantial functional limitations in three (3) of the areas of life activity listed below.

<p>This applicant is limited in three (3) or more of the areas of life activity listed below.</p> <p>Indicate by placing X in appropriate box</p> <p><input type="checkbox"/> Self care (ability to take care of basic life needs for food, hygiene and appearance).</p> <p><input type="checkbox"/> Receptive and expressive language (ability to both understand others and to express ideas or information to others either verbally or non-verbally).</p> <p><input type="checkbox"/> Learning (ability to acquire new behaviors, perceptions, information and to apply experiences to new situations).</p> <p><input type="checkbox"/> Mobility (ability to ambulate or move from one location to another independently).</p> <p><input type="checkbox"/> Self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's self).</p> <p><input type="checkbox"/> Capacity for independent living (age-appropriate ability to live without extraordinary assistance, to include maintaining adequate employment and financial support).</p>	<p style="text-align: center;"><u>Mental Retardation Diagnosis Onset:</u></p> <p><input type="checkbox"/> Infancy</p> <p><input type="checkbox"/> Developmental (below age 18)</p> <p><input type="checkbox"/> Age 18 years and above</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 50%; text-align: center; padding: 5px;"><u>IQ Level</u></td> <td style="width: 50%; text-align: center; padding: 5px;"><u>Adaptive Functioning Level</u></td> </tr> <tr> <td style="text-align: center; padding: 5px;"><input type="checkbox"/> Mild</td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/> Mild</td> </tr> <tr> <td style="text-align: center; padding: 5px;"><input type="checkbox"/> Moderate</td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/> Moderate</td> </tr> <tr> <td style="text-align: center; padding: 5px;"><input type="checkbox"/> Severe</td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/> Severe</td> </tr> <tr> <td style="text-align: center; padding: 5px;"><input type="checkbox"/> Profound</td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/> Profound</td> </tr> </table>	<u>IQ Level</u>	<u>Adaptive Functioning Level</u>	<input type="checkbox"/> Mild	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Severe	<input type="checkbox"/> Profound	<input type="checkbox"/> Profound
<u>IQ Level</u>	<u>Adaptive Functioning Level</u>										
<input type="checkbox"/> Mild	<input type="checkbox"/> Mild										
<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderate										
<input type="checkbox"/> Severe	<input type="checkbox"/> Severe										
<input type="checkbox"/> Profound	<input type="checkbox"/> Profound										

This individual has received a psychological examination as required under applicable state and federal regulations.

Signature of Program Representative Submitting Form: _____

Physician's Signature: _____ Date: _____

The applicant listed above is certified as meeting the ICF/MR level of care by DMH/MR:

APPROVED NOT APPROVED

Signature: _____ Regional QMRP. Date: _____