West Virginia Department of Health and Human Resources
Children with Disabilities Community Services Program (CDCSP)
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
Level of Care Evaluation

__ **Initial** ___**Annual Renewal**

I. Demographic Information (May be completed by Service Coordinator or Family Member)

1. Individual's Full Name	2. Sex F__ M__			3. Medicaid # (Required)
4. Address (including Street/Box, City, State & Zip) ________________________________ Phone: ( )				
5. County	6. Social Security#	7. Birthday (MM/DD/YY)	8. Age	9. Phone
10. Parents' Name		11. Children with Special Needs #		
11. List Current Medications Name of Medication Dosage Frequency ________________________________ ________________________________ ________________________________ ________________________________ ________________________________ ________________________________ ________________________________ ________________________________				
13. Living Arrangement ___ Natural Family ___ Adoptive Family ____Foster Family				
14. Private Insurance ___Yes ___ No Name of Company ________________________				
15. Significant Health History (include recent hospitalization(s) and/or surgery(ies) with dates, history of infectious disease) ________________________________ ________________________________ ________________________________ ________________________________ ________________________________ ________________________________ ________________________________				

Name of Applicant/Member: ____________________________ Date: ____________________

II. **MEDICAL ASSESSMENT** (Must be Completed by Physician):

16. Height	Weight	BP	P	R	T
17. Allergies:					

Code: V= Normal N=Not Done (Please explain why) NA=Not applicable X=Abnormal (Please describe)

Skin		
Eyes/Vision		
Nose		
Mouth		
Throat		
Swallowing		
Lymph Nodes		
Thyroid		
Heart		
Lungs		
Breast		
Abdomen		
Extremities		
Spine		
Rectal (Males include Prostate)		
Genitalia		
Bi-Manual Vaginal		
Vision		
Dental		
Hearing		
	Neurological	
Alertness		
Coherence		
Attention Span		
Speech		
Sensation		
Coordination		
Gait		
Muscle Tone		
Reflexes		

Name of Applicant/Member: ___________________________ Date: ____________________

II. Medical Assessment (Continued)
Problems Requiring Special Care (check all appropriate blanks)

MOBILITY		CONTINENCE STATUS		MEAL TIMES	
Ambulatory	____	Continent	__________	Eats independently	____
Ambulatory w/human help	____	Incontinent	__________	Needs Assistance	____
Ambulatory w/mechanical help	____	Not toilet trained	__________	Needs to be fed	____
Wheelchair self-propelled	____	Catheter	__________	Gastric/J tube	____
Wheelchair w/assistance	____	Ileostomy	__________	Special diet	____
Immobile	____	Colostomy	__________		

PERSONAL HYGIENE/SELF CARE		**MENTAL/BEHAVIOR DIFFICULTIES**		**COMMUNICATION**	
Independent	______	**Alert**	_______	**Communicates verbally**	___
Needs assistance	______	**Confused/Disoriented**	_______	**Communicates with sign**	___
Needs total care	_______	**Irrational behavior**	_______	**Communicates/assistive device**	___
		Needs close supervision	_____	**Communicates/hearing aid**	____
		Self-injurious behavior	_____	**Communicates/gestures**	____
		EPS/Tardive Dyskinesia	_____	**Limited Communication**	____

CURRENT THERAPEUTIC MODALITIES

VISION THERAPY	_______	**TRACTION, CASTS**	_____	**SOAKS, DRESSINGS**	_____
SPEECH THERAPY	_______	**OXYGEN THERAPY**	_____	**IV FLUIDS**	_____
OCCUPATIONAL THERAPY	_______	**SUCTIONING**	_____	**VENTILATOR**	_____
PHYSICAL THERAPY	_______	**TRACHEOSTOMY**	_____	**DIAGNOSTIC SERVICES**	_____

ADD ADDITIONAL SHEET IF NECESSARY

PLEASE COMPLETE ALL SECTIONS BELOW TO ENSURE CERTIFICATION FOR THE PROGRAM

DIAGNOSTIC SECTION:

AXIS I. (List all Emotional and/or Psychiatric Conditions)

AXIS II. (List all Cognitive, Developmental conditions and Personality disorders)

AXIS III. (List all Medical conditions)

PROGNOSIS AND RECOMMENDATIONS FOR FURTHER CARE:

I CERTIFY THAT THIS INDIVIDUAL'S DEVELOPMENTAL DISABILITY, MEDICAL CONDITION AND/OR RELATED HEALTH NEEDS ARE AS DOCUMENTED ABOVE AND HE/SHE REQUIRES THE LEVEL OF CARE PROVIDED IN AN ICF/IID.

AS AN ALTERNATIVE, THIS CHILD CAN BE SERVED BY:
CHILDREN WITH DISABILITIES COMMUNITY SERVICE PROGRAM _______Yes ______ No

___________________________ ____________________________________ ______________________
DATE **PHYSICIAN'S SIGNATURE** **LICENSE #**

FOR DEPARTMENT OF HEALTH AND HUMAN RESOURCES USE ONLY