COLORADO
Department of Health Care Policy & Financing

Intermediate Care Facility/Individual with Intellectual Disabilities (ICF/IID) Plan of Care for Admission Form

This form should be completed by medical professionals and will assist in the timely processing of ICF/IID admission reviews.

- It should be used by medical practitioners to ease the burden of multiple documents, prevent missing required items, and to expedite the admission process.
- It will provide guidance in accessing if an ICF/IID is the appropriate level of care and to assist in navigating the admission requirements.

ICF/IID is an optional Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence. They provide supportive care and nursing supervision under medical direction 24-hours per day. They stress rehabilitation therapy that enable individuals to return to a community setting. A full range of medical, social, recreational and support services are also provided. This comprehensive approach to helping individuals acquire the skills necessary for maximum independence--and to helping them maintain optimal functioning--is referred to as Active Treatment. Active Treatment is the cornerstone of the ICF/IID program and involves a comprehensive team approach to teaching individuals' critical skills and behaviors. In general, the goal of Active Treatment requirement is to assure that individuals acquire behaviors that help them to function as independently as possible.

Before admission the Case Management Agency (CMA) must facilitate documenting the individual's need for Active Treatment, their Level of Care needs, an evaluation, which includes background information and assessments of the individual's functional, developmental, behavioral, social, health and nutritional status. The purpose of the evaluation is to assure that the facility can meet the member's needs and that the member will benefit from placement in the facility. Collectively, this is referred to as the Plan of Care.

Return this completed form to the CMA Case Manager

Member Information	
Name:	
Date of Birth:	Medicaid ID:

Summary/Narrative
Discuss what has changed to require level of care change: • Diagnosis *(Medical/ Mental Health and intellectual disability)*, • Symptoms *(Current)*, • Complaints *(Current)*, • Complications *(Current)* indicating the need for admission, • Description of the individual's functional level *(mild, moderate, severe, profound ID),* and • Objectives/Goals

Physician's Orders – Indicate any (and ALL) orders for the following sections.

Medication – current medication orders (dose and indication)

☐ Not needed at this time

If not needed, discuss how was that determination made?

Treatment – wound care, skin treatment, nebulizers

☐ Not needed at this time

If not needed, discuss how was that determination made?

Restorative or Rehabilitative Services – such as restorative physical therapy

☐ Not needed at this time

If not needed, discuss how was that determination made?

Physician's Orders – Indicate any (and ALL) orders for the following sections.

Activities – physical activities (if none, state none)

☐ Not needed at this time

If not needed, discuss how was that determination made?

Therapies – physical, occupational, speech, respiratory, etc.; not behavioral

☐ Not needed at this time

If not needed, discuss how was that determination made?

Social Services – Any social services needing to be addressed, such as ongoing public benefits

☐ Not needed at this time

If not needed, discuss how was that determination made?

Physician's Orders – Indicate any (and ALL) orders for the following sections.
Diet – current orders (if none, state none)
☐ Not needed at this time
If not needed, discuss how was that determination made?
Special Procedures designed to meet the objectives of the Plan of Care – (Medical procedures ex: lab orders, finger sticks etc.)
☐ Not needed at this time
If not needed, discuss how was that determination made?

Discharge (from ICF/IID services) Plan
Specify what goals need to be met for this admission for the member to be returned to a lower level of care:

Order for ICF/IID Level of Care – Statement of Need from Physician

Physician Signature:
Date signed:

Return this completed form to the CMA Case Manager

If you have any questions regarding the information needed, contact:

Mary Mangelsen

ICF/IID & Regional Center Policy Specialist

Colorado Department of Health Care Policy & Financing

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