Level of Care Determination

Client Meets Level of Care Yes ☐ No ☐

Activities of Daily Living Scores:

	Bathing	Dressing	Toileting	Mobility	Transfers	Eating	Supervision Behaviors	Supervision Memory/Cognition
Scores:								

Is there documented medical information supporting any of the following programs?
Autism ☐ HCBS Children's ☐ EBD ☐ MI ☐ BI ☐ PLWA ☐

Has Developmental Disability eligibility been determined?
Yes ☐ No ☐

Comments/Supporting documentation:

Services Requirements

Waiver Services Needed within 30 Days Yes ☐ No ☐ ☐ **Waitlist** **Waiver:**

If Waiver Services are not required within 30 days document referral to community resources:
Comments:

Nursing Facility PASARR Determination

PASARR Level 1 evaluation Completed ☐ Client Passed ☐ Client Failed ☐

☐ Depression Diversion Client Passed ☐ Client Failed ☐

☐ Level II Evaluation Needed Referred to MHASA ☐ Date Referred to CCB ☐ Date:

Comments:

Long Term Care Certification

☐ Admission ☐ CSR

SSN: - - State ID:

Last Name: First Name: MI: DOB:

County of Residence: Date of Medicaid Application:

Facility Name: Provider #: Admit Date:

DO NOT COMPLETE BELOW IF CLIENT IS APPROVED FOR WAITLIST

Target Group

- ☐ 1 Developmental Disability/MR
- ☐ 2 Mental Health
- ☐ 3 Frail Elderly (65+)
- ☐ 4 Physically Disabled (18-64)
- ☐ 5 Physically Disabled (13-17)
- ☐ 6 Pediatric (<13)
- ☐ 7 Brain Injury (16-64)

Program Approval

- ☐ HCBS/DD (Comprehensive)
- ☐ HCBS/MI
- ☐ HCBS/EBD
- ☐ HCBS/PLWA
- ☐ Children's HCBS
- ☐ Nursing Home
- ☐ HCBS/BI
- ☐ HCBS/CES
- ☐ HCBS/BI Supported Living
- ☐ PACE
- ☐ ICF/MR
- ☐ LTC- Skilled Home Health
- ☐ HCBS/SLS
- ☐ HCA
- ☐ AFC
- ☐ HCBS/CHRP

Certification Information

Confirmation #:
Start Date:
End Date:
Authorized By:
Agency
Authorization Date:

Denial Information

Date Denied:
Date Denial Letter Mailed:
Case Mgr. Initials