STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
LEVEL OF CARE ELIGIBILITY DETERMINATION (LCED) FORM

For Home and Community Based Services (HCBS) Waiver, Comprehensive Care Coordination and other State Plan Services.
Please refer to the accompanying Instructions for information on completing this form.

Clear Form

Name of Individual			D.O.B.
Address			
Responsible Medicaid District	Individual's Medicaid (CIN)		Status: 620/621
Dates of Pre-Enrollment Evaluations: Physical / Social / Psychological			TABS ID #:

This Information must be kept Confidential by Recipient

ELIGIBILITY DETERMINATION CRITERIA

1. DIAGNOSIS: A. Intellectual Disability ☐ C. Autism ☐ E. Cerebral Palsy ☐ G. Prader-Willi Syndrome ☐
B. Epilepsy ☐ D. Neurological Impairment ☐ F. Familial Dysautonomia ☐ H. Other ☐:_____

2. DISABILITY MANIFESTED PRIOR TO AGE 22: YES ☐ NO ☐

3. SEVERE BEHAVIOR PROBLEM: YES ☐ NO ☐
A. Daily ☐ **B**. Weekly ☐ **C.** Monthly ☐ **D**. Occurred in past 12 months ☐

4. HEALTH CARE NEED: YES ☐ NO ☐

A. Individual has a medical condition which requires daily individualized attention from health care staff	YES ☐	NO ☐
B. Individual displays self-injurious behavior which necessitates monitoring and treatment	YES ☐	NO ☐
C. Individual has deficits in self-care skills	YES ☐	NO ☐
1. Extremely limited self-help skills, requires total assistance with self-care tasks	YES ☐	NO ☐
2. Demonstrates some self-help skills, but requires assistance and training in performing self-care tasks	YES ☐	NO ☐

5. ADAPTIVE BEHAVIOR DEFICIT: YES ☐ NO ☐

A. COMMUNICATION: YES ☐ NO ☐		
1. Individual has extremely limited expressive or receptive language skills	YES ☐	NO ☐
2. Individual has some expressive or receptive language but requires assistance to communicate needs	YES ☐	NO ☐
B. LEARNING: YES ☐ NO ☐		
1. I.Q. score cannot be determined using standardized test measures (certified untestable)	YES ☐	NO ☐
2. I.Q. score of less than 50	YES ☐	NO ☐
3. Over 21 years of age, person's reading and computation skills are at first grade level or below	YES ☐	NO ☐
4. I.Q. score of 50 – 69	YES ☐	NO ☐
5. Over 21 years of age, person's reading and computational skills are at third grade level or below	YES ☐	NO ☐
C. MOBILITY: YES ☐ NO ☐		
1. Individual is non-ambulatory and totally dependent on staff for moving from one place to another	YES ☐	NO ☐
2. Individual has some mobility skills but needs staff assistance and training to increase his/her capacity for moving about	YES ☐	NO ☐
D. CAPACITY FOR INDEPENDENT LIVING: YES ☐ NO ☐		
1. Individual is completely dependent on others for all household activities	YES ☐	NO ☐
2. Individual needs assistance or training to perform tasks to be a contributing member of household	YES ☐	NO ☐
E. SELF-DIRECTION: YES ☐ NO ☐		
1. Individual exhibits frequent (e.g., weekly) challenging behaviors requiring individualized programming	YES ☐	NO ☐
2. Individual is completely dependent on others for management of his/her personal affairs within the general community	YES ☐	NO ☐
3. Individual exhibits episodic (e.g., monthly) challenging behaviors requiring individualized programming	YES ☐	NO ☐
4. Individual needs assistance or training for management of his/her personal affairs within the general community	YES ☐	NO ☐

See Next Page for Required Signatures

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Name of Individual:	Individual's Medicaid (CIN):

Signature of Qualified Person Completing the Form	Review Date (mm/dd/yyyy)
Signature of Review Physician or Nurse Practitioner	Review Date (mm/dd/yyyy)

This Section is to be completed by the Developmental Disabilities Regional Office (DDRO) Director (or Designee) for Initial LCED Determinations Only	
Has the OPWDD process for Developmental Disability (DD) Eligibility been completed by the DDRO? YES ☐ NO ☐	
☐ ICF/IID Level of Care Approved Effective (mm/dd/yyyy):	☐ ICF/IID Level of Care NOT Approved
Signature of DDRO Director (or Designee):	Date (mm/dd/yyyy):

Annual ICF/IID 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/IID 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 ICF/IID level of care. The LCED is re-determined 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 (mm/dd/yyyy)**

Note: If an individual no longer meets the ICF/IID Level of Care, the DDRO must immediately be contacted for further action.