West Virginia Department of Health and Human Resources
ICF/IID Level of Care Evaluation

☐ **Initial** ☐ **Annual Renewal**

Service Coordination Agency: _____
Address: _____
Service Coordinator: _____
Contact Person: _____
Date: _____

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. Birthdate (MM/DD/YY)	8. Age	9. Phone

10.Spouse's Name	11. Address (if different from above)

12. List Current Medications

Name of Medication	Dosage	Date Started	Reason

13. Check if applicant has any of the following:

☐ Guardian ☐ Power of Attorney ☐ Other_____
☐ Committee ☐ Durable Power of Attorney
☐ Medical Power of Attorney ☐ Living Will

Name & Address of Representative:
_____
_____
_____
Phone ( )

14. Living Arrangement

☐ Natural/Adoptive Family ☐ Specialized Family Care Provider ☐ ISS–Two Person (Intensive support setting)
☐ Group Home (4 or more persons) ☐ ISS–One Person (Intensive support setting) ☐ ISS–Three Person (Intensive support setting)

15. Significant Health history – (include recent hospitalization(s) and/or surgery(ies) with dates, history of infectious disease)

_____
_____
_____
_____
_____

II. MEDICAL ASSESSMENT (MUST BE COMPLETED BY PHYSICIAN) **NAME:**_____

DATE:_____

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

CODE: √ **= NORMAL** **N** = **NOT DONE** (PLEASE EXPLAIN WHY) **NA = NOT APPLICABLE** **X = ABNORMAL** (PLEASE DESCRIBE)

SKIN		
EYES/VISION		
NOSE		
THROAT		
MOUTH		
SWALLOWING		
LYMPH NODES		
THYROID		
HEART		
LUNGS		
BREAST		
ABDOMEN		
EXTREMITIES		
SPINE		
GENITALIA		
RECTAL (MALES INCLUDE PROSTATE)		
BI-MANUAL VAGINAL		
VISION		
DENTAL		
HEARING		

NEUROLOGICAL

ALERTNESS		
COHERENCE		
ATTENTION SPAN		
SPEECH		
SENSATION		
COORDINATION		
GAIT		
MUSCLE TONE		
REFLEXES		

NAME _____ 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	_____
Ambul. w/ Mechanical help	_____	Not Toilet trained	_____	Needs to be fed	_____
Wheelchair self-propelled	_____	Catheter	_____	Gastric/J tube	_____
Wheelchair w/ assistance	_____	Ileostomy	_____	Special Diet	_____
Transfer w/ assistance	_____	Colostomy	_____		
Immobile	_____				

PERSONAL HYGIENE/SELF CARE		MENTAL/BEHAVIORAL 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 patient's developmental disability, medical condition and related health care needs are as documented above AND the patient requires the level of care and services provided in an "INTERMEDIATE CARE FACILITY" for individuals with Intellectual Disability and/or Related Conditions.

_____ Yes _____ No

_____ _____ _____

DATE **PHYSICIAN'S SIGNATURE** **LICENSE #**

FOR DEPARTMENT OF HEALTH AND HUMAN RESOURCES USE ONLY

APPROVED FOR ICF/IID LEVEL OF CARE: _____ **YES** _____ **NO**

NAME OF REVIEWER: _____ DATE APPROVED: _____