

DODD HCBS Initial Waiver Application

Applicant First Name:		Applicant Last Name:		County:		Waiver Type: <input type="checkbox"/> Lvl 1 <input type="checkbox"/> I/O <input type="checkbox"/> SELF <input type="checkbox"/> TDD	
DODD #:	Social Security #:	Date of Birth:	Medicaid Case # (10-digits):		SELF classification: <input type="checkbox"/> Child <input type="checkbox"/> Adult		
Household Mailing Address:						JFS Form 2399 Signature Date:	
Guardian Name:				Guardian Address:			
ICF/IID LEVEL OF CARE: Initial Eligibility Determination							
1. The individual meets the minimum criteria for Protective Level of Care						<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Attach a medical evaluation and a psychological/psychiatric evaluation that verifies this diagnosed condition.</u> 2a. Diagnosed condition(s) that establish(es) the individual's developmental disability (age 6 and above)							
2b. Developmental delays assessed for individuals birth through age five Adaptive Behavior / Physical development or maturation, fine and gross motor skills, growth / Cognition / Communication / Social or Emotional Development / Sensory Development (5101:3-3-07)							
3. Was the condition manifested prior to age 22?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Is the condition likely to continue indefinitely?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Current substantial functional limitations: Can the individual perform the task independently, safely, consistently, without undue effort and in a reasonable time? (Based on functional assessment) Refer to OAC 5101:3-3-07							
i. 3 developmental delays (birth to age 5 only) as identified in 2b.						<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
ii. Capacity for Independent Living (age 6+)						<input type="checkbox"/> Yes	<input type="checkbox"/> No
iii. Communication (age 6+)						<input type="checkbox"/> Yes	<input type="checkbox"/> No
iv. Learning (age 6+)						<input type="checkbox"/> Yes	<input type="checkbox"/> No
v. Mobility (age 6+)						<input type="checkbox"/> Yes	<input type="checkbox"/> No
vi. Personal Care (age 6+)						<input type="checkbox"/> Yes	<input type="checkbox"/> No
vii. Self-direction (age 6+)						<input type="checkbox"/> Yes	<input type="checkbox"/> No
viii. Economic Self-Sufficiency (age 16+ only)						<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
6-7. Skill Acquisition: The individual could benefit from services and supports to promote the acquisition of skills and to decrease or prevent regression in the performance in areas where delays are indicated and agrees to participate in an individualized plan of services and supports.						<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Do you recommend ICF/IID Level of Care?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Proposed Waiver Begin Date:							
Service Support Administrator Signature/Date: (Please print or type)				Service Support Administrator Name :			
(DODD USE ONLY) ICF/IID Level of Care Approved: <input type="checkbox"/> Denied: <input type="checkbox"/> Signature: _____ Date of LOC Determination: _____ LOC DENIAL REVIEW: Manager Review Approved: <input type="checkbox"/> Denied: <input type="checkbox"/> Signature: _____ Date: _____				Application Denied or Withdrawn for other reason: <input type="checkbox"/> Other Reason for Denial: _____ Waiver Begin Date: _____ Application Review: Signature: _____ Date: _____			