DISABILITY AND ICF-MR LEVEL OF CARE DETERMINATION FOR AN OKDHS/DDSD WAIVER

A portion of DDSD waiver eligibility, per OAC 317:40-1-1, is the requirement that individuals be determined disabled, have a diagnosis of ID/MR, and require an ICF-MR level of care. This form is for OHCA use in determining these areas.

Applicant Name: _____

Date of Birth: _____ **SSN:** _____

Review Type (check one): ☐ Initial ☐ Annual

DISABILITY DECISION

1. Individual receives SSI and has a disability onset date?	☐ Yes	☐ No
2. Individual receives SSDI, is age 19 or older, and has a disability onset date?	☐ Yes	☐ No
*If yes to disability question 1 **OR** 2, continue to disability question 3.* *If no to disability question 1 **AND** 2, skip to disability question 4.*		
3. Does individual currently receive SSI or SSDI and also have a diagnosis of ID/MR?	☐ Yes	☐ No
If yes to disability question 3, the individual has a disability and a diagnosis of ID/MR. Skip to disability question 5. *If no to disability question 3, OHCA must determine if a categorical relationship exists and must also confirm a diagnosis of ID/MR. Continue to disability question 4.*		

4. *IF NO DIAGNOSIS OF ID/MR by SSA**, OHCA determines categorical relationship to SoonerCare.***

   Date of Psychological Evaluation: _____

   IQ: _____ Age of disability onset: _____

   Name of Psychologist (please print): _____

   Does the individual have a diagnosis of ID/MR, made by a licensed Psychologist, and in accordance with SSA guidelines? ☐ Yes ☐ No

If yes, individual is determined disabled. Continue to disability question 5.

If no, packet is denied. Continue to disability question 5.

FINAL DISABILITY DECISION

5. The individual is determined disabled and has a diagnosis of ID/MR by SSA or OHCA?	☐ Yes	☐ No
If no to disability question 5, the packet is denied. Sign and date below. *If yes to disability question 5, forward this signed & dated form and packet for level of care determination (page 2 of this form).*		

_____ _____

Disability Evaluator Signature Date

ICF/MR LEVEL OF CARE DETERMINATION

Per OAC 317:30-5-122.b.3.

Date of Psychological Evaluation: _____

IQ: _____ Age of disability onset: _____

Name of Psychologist (please print): _____

1. Does the individual require active treatment (per 42 CFR 483.440)?	☐ Yes	☐ No
2. Does the individual have substantial functional limitations in three or more of the following areas of major life activity? *(Circle where substantial limitations exist)* ❖ Self-Care (needs assistance, training or supervision to eat, dress, groom, bathe or toilet) ❖ Understanding and Use of Language (unable to follow instruction, requires assistive technology device or lacks functional communication skills) ❖ Learning (diagnosis of ID/MR) ❖ Mobility (requires a device to be mobile) ❖ Self-Direction (age 7-17 and unable to make appropriate life decisions or age 18 or older and unable to provide informed consent, declared legally incompetent, or is a danger to himself or others) ❖ Capacity for Independent Living (age 7-17 and unable to use telephone and/or understand basic safety issues or age 18 or older who lacks basic skill in shopping, food preparation, housekeeping, or paying bills)	☐ Yes	☐ No

*If yes to level of care questions 1 **AND** 2, the individual meets ICF-MR level of care criteria. Continue to level of care question 3.*

*If no to level of care question 1 **OR** 2, the individual does not meet ICF-MR level of care criteria, therefore, packet is denied. Continue to level of care question 3.*

FINAL LEVEL OF CARE DECISION

3. OHCA determines the individual meets ICF-MR level of care criteria?	☐ Yes	☐ No

If no to level of care question 3, packet is denied. Sign and date below.

If yes to level of care question 3, the individual is approved for the DDSD waiver. Sign and date below.*

_____ _____

LOC Evaluator Signature Date

***Individual must be determined disabled, have a diagnosis of ID/MR and meet ICF-MR level of care criteria to qualify for DDSD waiver services.**