

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES OR INTELLECTUAL DISABILITIES (ICF-DD/ID) LEVEL OF CARE (LOC) AUTHORIZATION

1. PATIENT NAME (Surname, First Name, Middle Initial)		
2. MEDICAID ID NUMBER - V Digit	3. BIRTHDATE (Month/Day/Year)	4. AGE
To be Completed by Developmental Disabilities Division		
LEVEL OF CARE AUTHORIZATION REQUEST		
DD/ID Diagnosis/Condition:		
Psychologic Evaluation	Month:	Year:
	Intelligence Test Score:	Year:
	Adaptive Score(s):	Year:
The Developmental Disabilities Division (DDD) has determined that the above individual needs services at the ICF-DD/ID level of care. Qualified Intellectual Disabilities Professional Date		
To be Completed by Applicant/Beneficiary		
Read and Initial A. to acknowledge. A. _____ I understand that if I am found to have a disability for one year or more, the Department of Human Services will look at my assets to determine if I am still Medicaid eligible. If I go over my asset limit, I may lose my Medicaid eligibility. Signature of Applicant/Beneficiary Date Signature of Person Applying for Applicant/Beneficiary Relationship Date		
To be Completed by DHS Medical Consultant or Designee Only		
ICF-DD/ID LEVEL OF CARE DETERMINATION		
ICF-DD/ID Level of Care:	☐ Approved	☐ Disapproved
Comments:		
DHS/Designee Physician Signature Date		