DEPARTMENT OF HUMAN SERVICES

Return to: DHS/Med-QUEST Division
P. O. Box 339
Honolulu, HI 96809-0339

# INTERMEDIATE CARE FACILITY - MENTALLY RETARDED (ICF-MR) EVALUATION

**I. BIOGRAPHICAL (Please Type)**

| PATIENT (SURNAME, FIRST NAME, MIDDLE INITIAL) | DHS ID NUMBER | ✓ DIGIT | BIRTHDATE MONTH / DAY / YEAR | SEX | EFFECTIVE ADMISSION DATE MONTH / DAY / YEAR |
|---|---|---|---|---|---|
| | | | / / | | / / |

| PRESENT ADDRESS/FACILITY | CONTACT PERSON (ADDRESS/PHONE NO.) |
|---|---|
| PLACEMENT ADDRESS/FACILITY | CONTACT PERSON (ADDRESS/PHONE NO.) |

**II. DIAGNOSES:** ______________________

**III. VISION:** ______
**HEARING:** ______
**SPEECH:** ______
**SUPPLIES, DME:** ______

**IV. INTELLIGENCE TEST SCORE:** ______ **ADAPTIVE BEHAVIOR SCORE:** ______

**V. FUNCTIONAL ASSESSMENT:**

NOTE: Using scale (1 through 7), score blocks "C" (current functioning level) and "G" (functioning level attempting to achieve): 1 - totally dependent; 2 - maximum assist (hand over hand required); 3 - moderate touch (touch required); 4 - minimal assist (verbal cues/reminders only); 5 - supervision (visual monitor required); 6 - modified independent (with device); 7 - independent.

| BEHAVIOR | YES | NO | CURRENT | GOAL |
|---|---|---|---|---|
| SEXUALLY/SOCIALLY APPROPRIATE | [ ] | [ ] | [ ] | [ ] |
| SELF ABUSIVE | [ ] | [ ] | [ ] | [ ] |
| AGGRESSIVE | [ ] | [ ] | [ ] | [ ] |
| HEALTH, SAFETY, AND/OR COMMUNITY RISK | [ ] | [ ] | [ ] | [ ] |

| COMMUNICATIONN | YES | NO | CURRENT | GOAL |
|---|---|---|---|---|
| ADEQUATELY COMMUNICATES NEEDS/WANTS | [ ] | [ ] | [ ] | [ ] |
| UNDERSTANDS SIMPLE INSTRUCTIONS | [ ] | [ ] | [ ] | [ ] |
| USES OTHER COMMUNICATION TECHNIQUE/DEVICE | [ ] | [ ] | [ ] | [ ] |

| TRANSFER | YES | NO | CURRENT | GOAL |
|---|---|---|---|---|
| TRANSFERS FROM BED | [ ] | [ ] | [ ] | [ ] |
| TRANSFERS FROM CHAIR/TOILET | [ ] | [ ] | [ ] | [ ] |
| DOES NOT TRANSFER OR IS BEDFAST | [ ] | [ ] | [ ] | [ ] |

| MOBILITY | YES | NO | CURRENT | GOAL |
|---|---|---|---|---|
| MOVES ABOUT THE COMMUNITY | [ ] | [ ] | [ ] | [ ] |
| AMBULATES | [ ] | [ ] | [ ] | [ ] |
| WALKS WITH DEVICE | [ ] | [ ] | [ ] | [ ] |
| DOES NOT WALK | [ ] | [ ] | [ ] | [ ] |
| MOVES ABOUT IN A WHEELCHAIR | [ ] | [ ] | [ ] | [ ] |

| DRESSING | YES | NO | CURRENT | GOAL |
|---|---|---|---|---|
| PUTS ON ALL ITEMS OF CLOTHING | [ ] | [ ] | [ ] | [ ] |
| REMOVES ALL ITEMS OF CLOTHING | [ ] | [ ] | [ ] | [ ] |

| FEEDING | YES | NO | CURRENT | GOAL |
|---|---|---|---|---|
| FEEDS SELF USING UTENSILS | [ ] | [ ] | [ ] | [ ] |
| ASSISTS IN MEAL PREPARATION | [ ] | [ ] | [ ] | [ ] |
| FEEDS SELF WITH ADAPTIVE DEVICE | [ ] | [ ] | [ ] | [ ] |
| SPOON/SYRINGE FED (DOES NOT PARTICIPATE) | [ ] | [ ] | [ ] | [ ] |

| BOWEL AND BLADDER FUNCTION | YES | NO | CURRENT | GOAL |
|---|---|---|---|---|
| CONTINENT | [ ] | [ ] | [ ] | [ ] |
| PERFORMS STEPS IN BLADDER ELIMINATION | [ ] | [ ] | [ ] | [ ] |
| PERFORMS STEPS IN BOWEL ELIMINATION | [ ] | [ ] | [ ] | [ ] |

| PERSONAL HYGIENE | YES | NO | CURRENT | GOAL |
|---|---|---|---|---|
| BATHES SELF (ALL NECESSARY STEPS) | [ ] | [ ] | [ ] | [ ] |
| GROOMS SELF (COMBS HAIR, ETC.) | [ ] | [ ] | [ ] | [ ] |

| COGNITIVE/SOCIAL SKILLS | YES | NO | CURRENT | GOAL |
|---|---|---|---|---|
| MAKES OWN CHOICES | [ ] | [ ] | [ ] | [ ] |
| MANAGES MONEY | [ ] | [ ] | [ ] | [ ] |
| DOES HOUSEHOLD CHORES | [ ] | [ ] | [ ] | [ ] |
| DOES SHOPPING | [ ] | [ ] | [ ] | [ ] |
| CHOOSES/INITIATES LEISURE ACTIVITY | [ ] | [ ] | [ ] | [ ] |
| AWARE OF GENDER SIMILARITIES/DIFFERENCES | [ ] | [ ] | [ ] | [ ] |
| ACCESSES COMMUNITY RESOURCES | [ ] | [ ] | [ ] | [ ] |
| SOCIALLY INTERACTS WITH OTHERS | [ ] | [ ] | [ ] | [ ] |

**VI. MEDICAL/HEALTH PROCEDURES** (Use "D" if required daily, or "L" if Less than daily.)

| | D | L |
|---|---|---|
| 1. Intravenous or intramuscular therapy. | [ ] | [ ] |
| 2. Catheter Feeding (N/G or gastrostomy). | [ ] | [ ] |
| 3. Nasopharyngeal and tracheotomy aspiration. | [ ] | [ ] |
| 4. Dressings. | [ ] | [ ] |
| 5. Urinary Catheter with irrigation. | [ ] | [ ] |
| 6. Decubitis or skin disorders. | [ ] | [ ] |
| 7. Medical gases. | [ ] | [ ] |
| 8. Therapy: P.T., O.T., Speech. | [ ] | [ ] |
| 9. Other (Specify): ______ | | |

**VII. MEDICATIONS**

| | Supervision Required YES | Supervision Required NO | Administration on More Than One Shift YES | Administration on More Than One Shift NO |
|---|---|---|---|---|
| ______ | [ ] | [ ] | [ ] | [ ] |
| ______ | [ ] | [ ] | [ ] | [ ] |
| ______ | [ ] | [ ] | [ ] | [ ] |
| ______ | [ ] | [ ] | [ ] | [ ] |
| ______ | [ ] | [ ] | [ ] | [ ] |
| ______ | [ ] | [ ] | [ ] | [ ] |
| ______ | [ ] | [ ] | [ ] | [ ] |
| ______ | [ ] | [ ] | [ ] | [ ] |

**VIII. THERAPEUTIC** ______

**IX. HABILITATION**

| | YES | NO |
|---|---|---|
| Client needs active treatment 24-hours per day and facility services required. | [ ] | [ ] |
| Client does not need active treatment and waiver HCB services required. | [ ] | [ ] |
| Is the placement facility the least restrictive alternative environment available. | [ ] | [ ] |

**Placement Desired:** DD Domiciliary [ ] Adult Foster Home [ ] Own Home [ ] Other [ ]

**X. RECOMMENDED LEVEL OF CARE (LOC):** ICF-MR/Waiver Program: [ ] ICF-MR/Facility [ ] Other [ ]

______ Physician ______ / / Evaluation Date ______ R.N. ______ / / Evaluation Date

______ Psychologist ______ / / Evaluation Date ______ Social Worker ______ / / Evaluation Date

______ QMRP ______ / / IDPE CONFERENCE DATE

**XI. MEDICALLY APPROVED:** ICF-MR/Waiver Program [ ] ICF-MR/Facility [ ] Deferred [ ] Denied [ ] ______ / / Effective Date

NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE PATIENT BEING ELIGIBLE, THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. PATIENT ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE. AUTHORIZATION FOR THE PATIENT'S ADMISSION EXPIRES THIRTY (30) DAYS FROM THE DATE OF APPROVAL.

Reviewing Signature: ______ Date: / /

DHS 1150 (Revised 02/99) WHITE-Facility Copy YELLOW - Fiscal Intermediary PINK - MQD/MSB Copy