INSTRUCTIONS
DHS 1150

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

PURPOSE

The DHS 1150, Intermediate Care Facility-Mentally Retarded (ICF-MR) Evaluation form, shall be used to substantiate the need to ICF-MR services for the mentally related (MR) and/or person with developmental disabilities (DD) and recommend admission to the most appropriate program to best meet the needs of the individual.

GENERAL INSTRUCTIONS

1. This form shall be completed by the Qualified Mental Retardation Professional (QMRP) of the Interdisciplinary (ID) Team representing the individual in need of these services and submitted to Med-QUEST Division (MQD), Medical Standards Branch (MSB) for approval/disposition.

2. This form shall be completed based on individual professional evaluations completed by the following: Physician, Psychologist, Nurse, Social Worker and other appropriate professionals.

INSTRUCTIONS

1. BIOGRPAHICAL:

Line 1:

- Blocks 1 – 4 Self-explanatory.
- Block 5 Date of requested admission into expected program.

Line 2:

- Block 1 Address and name of current residence.
- Block 2 Self-explanatory. Include agency affiliation as needed.

Line 3:

- Block 1 Address and name of current residence.
- Block 2 Self-explanatory. Include agency affiliation as needed.

II. DIAGNOSIS

- List major diagnosis using ICD-9 codes.

III. **VISION; HEARING; SPEECH; SUPPLIES, DURABLE MEDICAL EQUIPMENT (DME):**

Lines 1 – 3:

- List diagnosis using ICD-9 codes whenever applicable.

Line 4:

- List items whenever applicable.

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

- Enter most recent test scores and dates.

V. **FUNCTIONAL ASSESSMENT:**

- Check yes or no whichever is applicable. Following instructions in shaded box, score current level and goal level for each functional item listed.

VI. **MEDICAL/HEALTH PROCEDURES**

- Numbers 1 – 9, self explanatory; to be completed by MD or RN only.

VII. **MEDICATIONS:**

- List all current medications and check boxes to the right as applicable.

VIII. **THERAPEUTIC DIET:**

- Name specific diet.

IX. **HABILITATION:**

- Self-explanatory. (Complete all items)

X. **RECOMMENDED LEVEL OF CARE (LOC):**

- Indicate the level of care (LOC) the Interdisciplinary Professional Evaluation (IDPE) identifies as the most appropriate.
- Required professional signatures, with date which indicates an evaluation was completed are: physician and/or nurse; psychologist, and social worker.
- Signature of qualified mental retardation professional (QMRP) with date indicates IDPE conference was held.