ODMR/DD Redetermination: Significant Change

APPLICANT INFORMATION

Name ______________________ **County** ____________ **Client #** __________

Date of Birth __________ **Social Security #** ________________

Household Mailing Address ____

Guardian ______________ **Address** ______________________________________

Waiver Type (check one) ☐Individual Options ☐Level 1

ICF/MR LEVEL OF CARE: Redetermination

1. The individual meets the minimum criteria for Protective Level of Care ☐Yes ☐No

2a. Diagnosed condition(s) that establish(es) the individual's developmental disability (age 6 and above) ____

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Attach a medical evaluation and a psychological/psychiatric evaluation that verify this diagnosed condition

2b. Developmental delays assessed for individuals birth through age five ____________________

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***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 disability manifested prior to age 22? ☐Yes ☐No

4. Is the disability likely to continue indefinitely? ☐Yes ☐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)	☐ N/A	☐ Yes	☐ No
ii. Capacity for Independent Living (age 6+)		☐ Yes	☐ No
iii. Communication (age 6+)		☐ Yes	☐ No
iv. Learning (age 6+)		☐ Yes	☐ No
v. Mobility (age 6+)		☐ Yes	☐ No
vi. Personal Care (age 6+)		☐ Yes	☐ No
vii. Self-direction (age 6+)		☐ Yes	☐ No
viii. Economic Self-Sufficiency (age 16+ only)	☐ N/A	☐ Yes	☐ 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. ☐Yes ☐No

8. Level of Care Recommendation: ICF/MR : ☐Yes ☐No

9. Proposed Waiver Begin Date: ____________________

Name: (Please print) ________________ **Title:** ____________________

SSA Signature: ______________________ **Date:** ______________

(ODMRDD USE ONLY)
ICF/MR Level of Care Approved: ☐ Denied: ☐

QMRP Signature ____________________

Date of LOC Determination ______________

LOC DENIAL REVIEW:
QMRP Manager Review Approved: ☐ Denied: ☐

Signature/Date ____________________

Application Denied or Withdrawn for other reason: ☐

Explanation: ____________________

Waiver Begin Date: ____________________

Waiver Manager Application Review:

Signature/Date ____________________