DHS
Oregon Department of Human Services
Aging and People with Disabilities
Office of Developmental Disability

Level of Care Assessment

Please print legibly and fill out completely. See SDS 520i instructions for further information regarding how to complete this form.

An individual meets the need for level of care (LOC) provided in an ICF/IDD for Behavioral, Comprehensive and Support Service Waiver Services or Community First Choice State Plan Services if the individual has a condition of intellectual disability (ID) or developmental disability (DD) and meets all eligibility criteria as specified in OAR 411-320-0080. This will be verified in the Eligibility Specialist section of this form. For more details regarding eligibility criteria see SDS 0520i. The individual must also have significant impairment in one or more areas of adaptive functioning as listed in the Level of Care Assessment section of this form. This will be verified by having one area in the Level of Care Assessment section rated a two (2) or above. Once the need for ICF/IDD LOC is determined and all other eligibility criteria are met, the individual may choose to receive services in an ICF/IDD or through the Comprehensive, Support Services or Behavioral Model Waiver and/or the Community First Choice State Plan option.

An individual meets the need for LOC provided in a Nursing Facility (NF) or Hospital if the individual has significant impairment in one or more areas of adaptive functioning as listed in the Level of Care Assessment section of this form and meets all financial eligibility criteria. This will be verified by having one area in the Level of Care Assessment section rated a two (2) or above. This will also require verification in the form of a signature from a DHS administrator and the medical director or designee on page 7 of this form. Once the need for NF or Hospital LOC is determined an all other eligibility criteria are met, the individual may choose to receive services in a NF or Hospital or through the 1915(c) Home and Community Based Waiver with the corresponding LOC and/or the Community First Choice State Plan Option.

Name: , Date of birth: - -

Individual information

Last:			First:		MI:
Date of birth *(mm - dd - yy)*: - -	Age:	Gender ☐ M ☐ F	Prime number:	County	

Eligibility Specialist

Developmental disability eligibility *(required except for medically involved waiver and hospital waiver)*:

☐ provisional ☐ adult

Eligibility diagnosis:

☐ intellectual disability ☐ mild (55–75) ☐ moderate (40–55)
☐ severe (20–40) ☐ profound (<20)

☐ Early Childhood Assessment

☐ other developmental disability only *(specify)*:

Significant impairments in adaptive behavior *(check all that apply, must have at least one)*:

☐ communication ☐ community use ☐ home or school living
☐ functional academics ☐ health and safety ☐ leisure
☐ mobility ☐ self care ☐ self direction
☐ socialization ☐ work

☐ IQ 65 or below (no adaptive assessment) ☐ composite score 70 or below (no domains reported)

☐ no adaptive assessment

☐ other:

I verify individual meets ID/DD eligibility criteria for DD services.

Signature eligibility specialist:	**Date** *(mm - dd - yy)*: - -

Name: , Date of birth: - -

Level of Care Assessment

(To be completed by SC/PA/CM) after file review and during or after face-to-face review; must be reviewed annually within 12 months. See instructions for further details.

Level of Care Assessment

Vision function with correction, if *needed (check one):*

☐ 1 full vision ☐ 2 difficulty at level of print ☐ 3 difficulty with obstacles ☐ 4 blind

☐ other: _____

Hearing function with correction, if *needed (check one):*

☐ 1 full hearing ☐ 2 difficulty at level of communication ☐ 3 difficulty with alarm sounds ☐ 4 deaf

☐ comments: _____

Self care *(check one)*:

☐ 1 no assists needed ☐ 2 occasional assists needed ☐ 3 daily assists needed

☐ 4 frequent assists needed ☐ 5 total assists needed

☐ comments: _____

Personal mobility status *(check one)*:

☐ 1 no assists needed for mobility

☐ 2 occasional assists needed for mobility but mobile

☐ 3 adaptive equipment but no assists needed for mobility

☐ 4 adaptive equipment needed and some assists needed for mobility –Needs assistance

☐ 5 adaptive equipment needed and full assists needed for mobility

☐ comments: _____

Communication — Expressive *(check all that apply)*:

☐ 1 speech easily understood ☐ 2 speech difficult to understand

☐ 3 uses sign language ☐ 4 uses gestures and/or some signs

☐ 5 uses alternative communication device ☐ 6 has no functional communication

☐ Comments: _____

Communication — Receptive *(check all that apply)*:

☐ 1 other's speech easily understood ☐ 2 other's speech difficult to understand

☐ 3 can understand sign language ☐ 4 can understand gestures and/or some signs

☐ 5 can understand others using alternative communication device

☐ 6 has no functional understanding of communication

☐ comments: _____

Name: , Date of birth: - -

Level of Care Assessment (continued).

Toileting assists *(check all that apply)*:

☐ 1 has full control bowel and bladder ☐ 2 occasional loss of control in day

☐ 3 incontinent or frequent loss of control ☐ 4 nighttime enuresis

☐ comments: _____

Medical needs *(check one)*:

☐ 1 generally has no serious medical needs ☐ 2 needs regular visits with nurse or visits to doctor

☐ 3 needs to have nurse on site daily but not constantly ☐ 4 needs personal nurse on site at all times

☐ comments: _____

Additional conditions and criteria:

☐ MICP score that meets criteria for NF waiver *(DD eligibility not required).*

☐ MFCU score that meets criteria for wavier enrollment *(DD eligibility not required).*

☐ BCS that meets criteria for waiver enrollment *(DD eligibility required).*

Observed behavior support needs within the last 12 months *(check all that apply)*:

☐ 1 none ☐ 2 behaviors, but not injurious ☐ 3 injurious to self

☐ 4 Injurious to others ☐ other

☐ comments: _____

Diagnosed mental health and emotional disorders *(check all that apply)*:

☐ None ☐ Psychosis ☐ Depression ☐ Bipolar

☐ Personality disorder ☐ Other: _____

This person makes independent correct decisions:	**Comments**
1. Chooses clothing that is appropriate for the weather? 1 ☐ always 2 ☐ sometimes 3 ☐ never	
2. Recognizes and attends to signs/symptoms of illness? 1 ☐ always 2 ☐ sometimes 3 ☐ never	
3. Can identify threatening acts or gestures from other? 1 ☐ always 2 ☐ sometimes 3 ☐ never	
4. Will take action to protect self from threatening acts or gestures? 1 ☐ always 2 ☐ sometimes 3 ☐ never	
5. Independently able to ensure basic needs are met 1 ☐ always 2 ☐ sometimes 3 ☐ never	
6. Independently manages finances to ensure basic necessities are met *(example — banking, sufficient funds to cover basic necessities)?* 1 ☐ always 2 ☐ sometimes 3 ☐ never	

Name: , Date of birth: - -

Level of Care Assessment

Supports individual is currently receiving, or is required in the next 30 days to remain in the community (may be unpaid supports).

	Comments
Medical management (including but not limited to: OT, PT, medication, nursing, dietician, or other Medical Supports) ☐ Yes ☐ No	
Behavior management (including but not limited to: indirect/environmental modifications, Behavior Support Plan, psychologist, behavior specialists, medication management or other behavior management supports): ☐ Yes ☐ No	
Psychiatric services (including but not limited to: nursing, psychiatry services, therapy/counseling, medication management or other psychiatric services) ☐ Yes ☐ No	
Residential supports (including but not limited to: 24 hour, Foster Care, Supported Living, Paid In-Home, family, friends/advocates/other, or other residential supports) ☐ Yes ☐ No	
Community supports (including but not limited to: family, employment, community inclusion, non-medical transportation, friends/advocates/other, or other community supports) ☐ Yes ☐ No	

Check one: ☐ personal agent ☐ service coordinator ☐ choice advisor

Signature:	**Date** *(mm - dd - yy)*: - -

Name: , Date of birth: - -

Customer/guardian

Individual choice

By federal regulations, if you need services that may be available in an ICF/IDD, nursing facility or hospital setting, we must inform you of other available services and give you a choice of home and community based or institutional services *(ICF/IDD, nursing facility or hospital services)*.

1. **I have been informed of the choices available to me and have selected the following service:**
   ☐ ICF/IDD ☐ nursing facility ☐ hospital ☐ home and community-based
2. **By signing this document, I have reviewed my service needs and options with a representative of:** _____
3. ☐ **I have been notified of my fair hearing rights.**

Person signing: ☐ individual ☐ guardian ☐ parent *(of child 0–17)* ☐ designated representative

Signature:	**Date** *(mm - dd - yy)*: - -

☐ **Witness** ***(When customer is unable to sign and does not have a legal representative)***

Signature:	**Date** *(mm - dd - yy)*: - -

DHS administrative use only

Review and verification of ICF/IDD LOC: ☐ **Approved** ☐ **Disapproved**	
Signature *(Diagnosis and evaluation coordinator)*:	**Date** *(mm - dd - yy)*: - -
Signature *(DHS administrator or designee)*:	**Date** *(mm - dd - yy)*: - -
☐ **Review and approval of nursing facility LOC** ☐ **Review and approval of hospital**	
Signature *(DHS medical director or designee)*:	**Date** *(mm - dd - yy)*: - -
Signature *(DHS administrator or designee)*:	**Date** *(mm - dd - yy)*: - -

Termination from:	**Date:**	**Reason:**	**Date:**
☐ waiver	- -	☐ ineligible for Title XIX med card	- -
☐ Community First Choice State Plan:	- -	☐ death	- -
		☐ other: _____	- -
		☐ no longer in waivered service	- -
		☐ no longer in CFC	- -
		☐ legal	- -

Name: , Date of birth: - -

By signing below the SC/PA/CM and individual verify that the LOC Assessment and fair hearing rights were reviewed in their entirety in a way that the individual can understand.

Annual review of Level of Care (LOC)			
Date	**Next review**	**SC/PA/CM signature**	**Individual signature**
- -	- -		
- -	- -		
- -	- -		
- -	- -		
- -	- -		
- -	- -		
- -	- -		
- -	- -		
- -	- -		
- -	- -		
- -	- -		
- -	- -		
- -	- -		
- -	- -		