Client: Record Number:

Initial Level of Care Eligibility Determination
NC Innovations
☐ Prior Approval ☐ Utilization Review

Name _____
Last First Middle
Address _____
Date of Birth _____ Gender _____
County of Medicaid Eligibility _____
MID# _____ Address _____
Legally Responsible/Guardian _____
Phone # _____
Address _____

1. Living in ICF-MR Facility ☐Yes ☐No

2. Diagnosed condition(s) that establish(es) the individual's developmental disability
   Diagnosis:
   - ☐ Intellectual Disability (IQ or % of Developmental Delay) _____
   - ☐ Medical Condition: _____
   - ☐ Related Condition: _____

Was the disability manifested prior to age 22?	☐Yes	☐No
Is the disability likely to continue indefinitely?	☐Yes	☐No
Current substantial functional limitations: (Based on functional assessment)		
i. Self Care	☐Yes	☐No
ii. Understanding/Use of Language	☐Yes	☐No
iii. Learning	☐Yes	☐No
iv. Mobility	☐Yes	☐No
v. Self-direction	☐Yes	☐No
vi. Capacity for Independent Living	☐Yes	☐No
The individual could benefit from services and supports to promote the acquisition of skills, and to decrease or prevent regression.	☐ Yes	☐ No

6. **Level of Care Recommendation:**
   ☐ Eligible ICF-MR ☐ Not Eligible ICF-MR
   Psychologist/Licensed Psychological Associate _____ Date: _____
   Physician _____ Date: _____

(MCO USE ONLY)
ICF/MR Level of Care Approved: _____ Denied: _____
LOC Effective Date: _____
Prior Approval Number _____

_____
UM Clinical Care Manager/Signature/Date

_____
Medical Director Signature (if applicable) Date