Vaya Health

Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) Level of Care Eligibility Determination

☐ Prior Approval ☐ Utilization Review

Member Name: _____ _____ _____
Last *First* *Middle*

Address: _____

Date of Birth: _____ Gender: _____

County of Medicaid Eligibility: _____ MID #: _____

Legally Responsible Person (LRP)/Guardian Name: _____ LRP Phone: _____

LRP Address: _____

1. Living in ICF/IID facility? ☐ Yes ☐ No

2. Diagnosed condition(s) that establish(es) the individual's developmental disability:
   - ☐ Intellectual/developmental disability (diagnosis/diagnostic code): _____
   - ☐ Medical condition: _____
   - ☐ Related condition: _____

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 (based on functional assessment):

Self-care	☐ Yes	☐ No	Mobility	☐ Yes	☐ No
Understanding/use of language	☐ Yes	☐ No	Self-direction	☐ Yes	☐ No
Learning	☐ Yes	☐ No	Capacity for independent living	☐ Yes	☐ No

6. The individual could benefit from services and supports to promote the acquisition of skills and to decrease or prevent regression. ☐ Yes ☐ No

Level of Care (LOC) Recommendation: ☐ Eligible for ICF/IID ☐ Not eligible for ICF/IID

_____ _____
Physician Signature Date

_____
Physician Printed Name and Credentials

For Vaya Health Use Only

ICF/IID Level of Care: ☐ Approved ☐ Denied

LOC Effective Date: _____ Prior Approval Number: _____

_____ _____

UM Clinical Care Manager Signature Date

_____ _____

Medical Director Signature (if applicable) Date