**ICF/MR Level of Care:**

* Date of qualifying diagnosis and “By Whom matches support documentation
* Client’s age matches ICAP report
* DQ, SS, or BI completed as appropriate for age
* LOC based on new information. No if Renewal/same – Yes if New
* Backup documentation for diagnosis must be attached and include diagnostician name, degree, and agency
* ICAP summary report and booklet must be attached when completed waiver packet sent to CO
* Primary diagnosis checked must match ICAP and backup docs
* ICAP Evaluator name on LOC matches evaluator on ICAP report
* Recipient or Family/Guardian same as person signing POC/Choice
* QMRP box checked
* Other Professionals box checked
* LOC decision box/one checked
* DD RPS signature and date
* Start and end date of LOC written in to agree with the POC

**CCMC Nursing Facility LOC: Circled box indicates missing item**

* DSDS Nurse signature w/in 90 days of DD Nurse signature
* NFLOC signed by physician or Phys. Assistant
* NFLOC complete and signed by DMA
* NFLOC completed by a RN
* Period of Care requested same as POC start/end date

**PLAN OF CARE: Circled box indicates missing item**

**POC Personal Information**

* All boxes are checked and/or completed, with information sufficient for contact, or marked N/A if not applicable. Email and cell phone information is optional
* Personal descriptive information must match ICAP
* Transition Plan – Yes if leaving family home, foster home or school setting

**POC Diagnosis**

* Primary Diagnosis listed matches ICFMR LOC, ICAP & NFLOC
* Secondary Diagnosis should include all diagnoses.
* Adaptive Equipment currently in use includes major items only consistent with individual presented in Section III
* Adaptive equipment listed as needed must be addressed as a service need in Section IV.

**POC Personal Snapshot**

A comprehensive description of talents, strengths, needs, and desires in the following areas are addressed in the narrative:

* Motor skills
* Social/Communication skills
* Personal living skills
* Community living skills
* Behaviors that require intervention by others
* Description is consistent with the information in the MRDD LOC or NFLOC
* Plans with skilled nursing must address/describe nursing needs
* Description justifies services described in Section IV and Goals and Objectives in Section V
* PCA screening addressed as applicable
* Transition/reunification, permanency, and/or ICWA plan if applicable
* Res. Hab. Rate Criteria Assessment signed/dated by agency nurse
* CCMC Training Checklist included

**POC Summary of Services**

* All categories of service must be addressed
* All Medicaid and grant funded services must have type, provider, how often, how long
* **ALL** service categories, regardless of funding, must have a description of service
* EM over $1000 has three estimates from licensed, bonded, insured providers attached
* EM has backup documentation with detailed break out of project with materials, labor, scope of work, etc.
* Waiver individual has not exceeded $10,000 for EM in past 3 years
* SME, regardless of cost, has physician request/prescription
* 7799 SME, regardless of cost, has picture and description
* SME over $500 has written statement from a qualified professional that they evaluated and find the equipment necessary and appropriate.
* SME regardless of cost has MSRP

**PLAN OF CARE – continued:**

**POC Goals and Objectives (Must be Measurable)**

* Each HCBW habilitative service must have goals and objectives except Care Coordination and Basic Respite
* Goal and objectives must be reflective of the service description
* Goal is a statement of the benefit or outcome of service to be provided.
* Objectives specify the habilitative services **for the consumer** that will increase or maintain skills, and reduce behaviors if applicable
* Criteria for goals and objectives are completed
* IAT Nursing must include the assessment and IAT plan (e.g. nursing care plan)

**POC Consumer Choice**

* All boxes must be completed by consumer in ink
* One box completed in ink in the “I choose to receive” section
* Signature of all planning team members
* IAT w/DD nurse requires physician and nurse on team
* INDIVIDUAL CHOICE OF SERVIES form must have all boxes, #1-8, checked, in ink, and
	+ Only one request for services checked in signature box section, **and**
	+ Signature of individual and/or legal representative

**PROVIDER AND WAIVER SERVICES OVERVIEW**

* CCAN
* Medicaid #
* Client name
* Address
* Date of birth
* Start date
* LOC Renewal Date
* New, Renewal, Amendment
* Continuing Care Coordination units correct: 11 new waiver 12 renewal
* Amended services identified (e.g. bolded, asterisk, or bullet)
* Services listed are valid Waiver service types
* Annualized units identified
* Correct codes for each type of service
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SDS FORMS**

* State ROI Forms for:

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* Expiration date
* Medicaid #
* Date of birth
* Person/organization releasing information
* Person/organization receiving information
* Description of information to be released
* Signatures
* Dates
* Grievance Procedures
* Notice of Appeals
* Care Coordination Appointment
* Change of Status
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTES:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_