MAP-620 11-'02

APPLICATION FOR SCL WAIVER AND ICF/MR SERVICES

THIS FORM MUST BE COMPLETED ENTIRELY

1. **Name** _____
   First **Middle** **Last**

   Social Security Number ___-___-___-___-___-___-___-___-___ **Sex: M ☐ or F ☐**

   Medical Assistance Number ___-___-___-___-___-___-___-___-___-___

   Date of Birth: ___-___ ___-___ ___-___-___-___ **Phone #:** ___-___-___-___-___-___-___-___-___-___
   day **month** **year**

   Present Address _____
   Street

   _____ ___-___-___-___-___-___-___-___-___
   City **County** **State** **Zip Code**

IF THIS SECTION IS COMPLETED, SIGNATURE OF GUARDIAN OR LEGAL REPRESENTATIVE IS REQUIRED BELOW.

2. **Legal Representative/Guardian (if applicable)** _____

   _____

   Address _____
   City **County** **State** **Zip Code**

   Phone _____ **Relationship to Applicant** _____

3. **Case Management Provider Name and Address (if applicable)**

   Name _____

   Address _____
   City **County** **State** **Zip Code**

_____ _____ _____
Applicant's Signature **Legal Rep./Guardian (if applicable)** **Date**

MUST BE SIGNED BY APPLICANT IF THERE IS NO GUARDIAN

4. **DSM Diagnosis:**
   Axis I (Mental Health): _____
   Axis II (Mental Retardation/Developmental Disability) : _____
   Axis III (Physical Health): _____
   Age Disability Identified: _____

5. **Please designate desired services:** ☐ **ICF/MR** ☐ **SCL Waiver**

_____ _____
Physician/QMRP Signature **Date**

PLEASE TELL US ABOUT THE APPLICANT BY CHECKING ONE BOX UNDER EACH HEADING.

6. MOBILITY

- ☐ Walks independently
- ☐ Walks with supportive devices
- ☐ Walks unaided with difficulty
- ☐ Uses wheelchair operated by self
- ☐ Uses wheelchair & needs help
- ☐ No mobility

Comments:_____

COMMUNICATION

- ☐ Speaks and can be understood
- ☐ Speaks and is difficult to understand
- ☐ Uses gestures
- ☐ Uses sign language
- ☐ Uses communication board or device
- ☐ Does not communicate

Comments:_____

7. HOW MUCH TIME IS REQUIRED FOR ASSURING SAFETY?

- ☐ Requires less than 8 hours per day on average
- ☐ Requires 9-16 hours daily on average
- ☐ Requires 24 hours (does not require awake person overnight)
- ☐ Requires 24 hours with awake person overnight
- ☐ **Extreme Need:** Requires 24 hours, awake person trained to meet individual's particular needs; continuous monitoring

COMMENTS:_____

8. HOW MUCH ASSISTANCE IS NEEDED FOR DAILY LIVING TASKS?

- ☐ **No assistance** needed in **most** self-help and daily living areas, and
  Minimal assistance ***(use of verbal prompts or gestures as reminders)*** needed **in some** self-help and daily living areas, and
  Minimal to complex assistance needed to complete complex skills such as financial planning and health planning.

- ☐ **No assistance** in **some** self-help, daily living areas, and
  Minimal assistance for many skills, and
  Complete assistance (*caregiver completes all parts of task)* needed in **some** basic skills and all **complex** skills.

- ☐ **Partial *(use of hands on guidance for part of task)* to complete assistance** needed **in most** areas of self-help, daily living, and decision making, and
  Cannot complete **complex** skills.

- ☐ **Partial to complete assistance** is needed **in all areas** of self-help, daily living, decision making, and complex skills

- ☐ **Extreme Need:** All tasks must be done for the individual, with no participation from the individual

COMMENTS:_____

9. HOW OFTEN ARE DOCTOR VISITS NEEDED?

- ☐ For routine health care only / once per year
- ☐ 2-4 times per year for consultation or treatment for chronic health care need
- ☐ More than 4 times per year for consultation or treatment
- ☐ **Extreme Need:** Chronic medical condition requires immediate availability and frequent monitoring

COMMENTS:_____
_____

10. HOW OFTEN ARE NURSING SERVICES NEEDED?

- ☐ Not at all
- ☐ For routine health care only
- ☐ 1-3 times per month
- ☐ Weekly
- ☐ Daily
- ☐ **Extreme Need:** Several times daily or continuous availability

COMMENTS:_____
_____

11. ARE THERE BEHAVIORAL PROBLEMS? Yes ☐ No ☐

IF YES-PLEASE CHECK ALL THAT APPLY.

- ☐ Self Injury
- ☐ Aggressive towards others
- ☐ Inappropriate sexual behavior
- ☐ Property destruction
- ☐ Life threatening (threat of death or severe injury to self or others)
- ☐ Takes prescribed medications for behavior control

PLEASE CHECK ONE ANSWER UNDER EACH QUESTION, UNLESS OTHERWISE INDICATED.

12. WHERE IS THE INDIVIDUAL CURRENTLY LIVING?

- ☐ Living with family/relative
- ☐ Group home or personal care home
- ☐ ICF/MR (Intermediate Care Facility)
- ☐ Living in own home or apartment
- ☐ Nursing home
- ☐ Living with a friend

13. DOES THE INDIVIDUAL CURRENTLY RECEIVE ANY OF THE FOLLOWING SERVICES? (CHECK ALL THAT APPLY)

- ☐ Supported Living
- ☐ Medicaid Aquired Brain Injury
- ☐ Supported Employment
- ☐ Home Health
- ☐ Other Medicaid Services
- ☐ Day Program
- ☐ School
- ☐ Behavior Support
- ☐ Transportation
- ☐ Speech Therapy
- ☐ Physical Therapy
- ☐ Medicaid EPSDT (if under 21)
- ☐ Medicaid Home & Community Based Waiver
- ☐ Mental Health Counseling or Medication for a mental health condition
- ☐ In home Support
- ☐ Residential
- ☐ Respite
- ☐ Occupational Therapy
- ☐ Support Coordination
- ☐ Other

14. WHAT SERVICES ARE NEEDED NOW OR IN THE FUTURE?

- ☐ Day Program
- ☐ School
- ☐ Respite
- ☐ Transportation
- ☐ Speech Therapy
- ☐ Physical Therapy
- ☐ Other
- ☐ In home Support
- ☐ Residential
- ☐ Behavior Support
- ☐ Occupational Therapy
- ☐ Support Coordination
- ☐ Supported Employment

15.THE FOLLOWING ARE 5 CHOICES FOR FUTURE LIVING ARRANGEMENTS. WHERE WOULD THE INDIVIDUAL CURRENTLY ON THE WAITING LIST PREFER TO LIVE IN THE FUTURE? CHOOSE ONLY ONE (1):

- ☐ At home with a family member with someone to come in and help
- ☐ In the person's own home with minimal supports
- ☐ In a 24 hour staffed residence in the community
- ☐ In a 24 hour supervised family home in the community
- ☐ In an ICF/MR

16. WHO IS THE PRIMARY CAREGIVER?

☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle
☐ Sister ☐ Brother ☐ Friend ☐ Neighbor ☐ Other: Who? _____

17. WHAT IS THE AGE OF THE PRIMARY CAREGIVER?

☐ Less than 30 years old ☐ 31-50 years old ☐ 51-60 years old ☐ 61-70 years old
☐ 71-80 years old ☐ Over 80 years old

18. THE PRIMARY CAREGIVER'S HEALTH STATUS COULD BE CLASSIFIED AS:

☐ Poor ☐ Stable ☐ Very Good

Comments: _____

_____

_____

Person Completing Application: _____
Print Name

_____
Relationship to Individual (if not individual)

_____
Phone Number

_____ _____
Signature Date

Additional Comments: _____

_____

_____