DD MEDICAID WAIVER
LEVEL OF FUNCTIONING SURVEY
SUMMARY SHEET

Recipient's Name:_____

NOTE: *The individual must meet the indicated dependency level in 2 or more of the following categories to justify need for services in a Medicaid-certified Intermediate Care Facility for individuals with Mental Retardation or to meet level of care eligibility requirement for the Individual and Family Developmental Disabilities Support Waiver (DD Waiver).*

Date:		Date:		Date:		
MET	NOT MET	MET	NOT MET	MET	NOT MET	See qualifying option in each category below:
						Category 1: Health Status 2 or more questions answered with a 4 or Question "j" answered yes
						Category 2: Communication Three or more questions answered with a 3 or 4
						Category 3: Task Learning Skills Three or more questions answered with a 3 or 4
						Category 4: Personal/Self Care Question "a" answered with a 4 or 5 Or Question "b" answered with a 4 or 5 Or Questions "c" and "d" answered with a 4 or 5
						Category 5: Mobility Any one question answered with a 4 or 5
						Category 6: Behavior: Any question answered with a 3 or 4
						Category 7: Community Living Skills Any two of questions "b", "e", or "g" answered With a 4 or 5; Or Three or more questions answered with a 4 or 5

Date:_____ Evaluators Signature:_____
Title/Affiliation: _____

Date:_____ Evaluators Signature:_____
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Instructions for Completing
DD Medicaid Waiver
Level of Functioning Survey

For determining level of care eligibility for DD Waiver services, consider the individual's functioning in community environments. Complete the attached survey presuming the needed services and supports are not in place for the individual. Please note that, for items in a Health Status section, needed care or supervision may be provided by care givers other than a licensed nurse.

DEFINITIONS:

"No Assistance" means no help is needed.

"Prompting/Structuring" means prior to the functioning, some verbal direction and/or some rearrangement of the environment is needed.

"Supervision" means that a helper must be present during the functioning and provide only verbal direction, gestural prompts, and/or guidance.

"Some Direct Assistance" means that a helper must be present and provide some physical guidance/support (with or without verbal direction).

"Total Care" means that a helper must perform all or nearly all of the functions.

"Rarely" means that the behavior occurs quarterly or less.

"Sometimes" means that a behavior occurs once a month or less.

"Often" means that a behavior occurs 2-3 times a month.

"Regularly" means that a behavior occurs weekly or more.

Consumer Name:_____

LEVEL OF FUNCTIONING SURVEY

1. HEALTH STATUS
   How often is nursing care or nursing supervision by a licensed nurse required for the following?

   Please put appropriate number in the box under year of assessment.
   (Key: 1= Rarely, 2=Sometimes, 3=Often, and 4=Regularly)

	Date:	Date:	Date:
a.) Medication administration and/or evaluation for effectiveness of a medication regimen			
b.) Direct services: i.e., care for lesions, dressings, treatments, (other than shampoos, foot powder, etc.)			
c.) Seizure Control			
d.) Teaching diagnosed disease control and care, including diabetes			
e.) Management of care of diagnosed circulatory or respiratory problems			
f.) Motor disabilities which interfere with all activities of Daily Living - Bathing, Dressing, Mobility, Toileting, etc.			
g.) Observation for choking/aspiration while eating, drinking			
h.) Supervision of use of adaptive equipment, i.e., special spoon, braces, etc.			
i.) Observation for nutritional problems (i.e., undernourishment, swallowing difficulties, obesity)			
j.) Is age 55 or older, has a diagnosis of a chronic disease and has been in an institution 20 years or more			

Consumers Name:_____

2. COMMUNICATION
How often does this person:

Please put appropriate number in the box under the year of assessment.
(Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)

	Date:	Date:	Date:
a.) Indicate wants by pointing, vocal noises, or signs?			
b.) Use simple words, phrases, short sentences?			
c.) Ask for at least 10 things using appropriate names?			
d.) Understand simple words, phrases or instructions containing prepositions: i.e., “on”, “in”, “behind” ?			
e.) Speak in an easily understood manner?			
f.) Identify self, place or residence, and significant others?			

3. TASK LEARNING SKILLS
How often does this person perform the following activities?

Please put the appropriate number in the box under the year of assessment.
(Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)

	Date:	Date:	Date:
a.) Pay attention to purposeful activities for 5 minutes?			
b.) Stay with a 3-step task for more than 15 minutes?			
c.) Tell time to the hour and understand time intervals?			
d.) Count more than 10 objects?			
e.) Do simple addition, subtraction?			
f.) Write or print 10 words?			
g.) Discriminate shapes, sizes or colors?			
h.) Name people or objects when describing pictures?			
i.) Discriminate between “one”, “many”, “lot”?			

Consumers Name:_____

4. PERSONAL/SELF-CARE
   With what type of assistance can this person currently:

   Please put appropriate number in the box under year of assessment
   (Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Perform toileting functions i.e., maintain bladder and bowel continence, clean self, etc.?			
b.) Perform eating/feeding functions: i.e., drink liquids and eat with spoon or fork, etc.?			
c.) Perform bathing function: i.e., bathe, run bath, dry self, etc.?			
d.) Dress self completely, i.e., including fastening and putting on clothes?			

5. MOBILITY
   With what type of assistance can this person currently:

   Please put appropriate number in the box under the year of assessment.
   (Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Move (walking, wheeling) around environment?			
b.) Rise from lying down to sitting positions, sit without support?			
c.) Turn and position in bed, roll over?			

Consumers Name:_____

6. BEHAVIOR
   How often does this person:
   Please put appropriate number in the box under the year of assessment.
   (Key: 1=Rarely, 2=Sometimes, 3=Often, 4=Regularly)

	Date:	Date:	Date:
a.) Engage in self-destructive behavior?			
b.) Threaten or do physical violence to others?			
c.) Throw things or damage property, have temper outbursts?			
d.) Respond to others in a socially unacceptable manner (without undue anger, frustration or hostility)?			

7. COMMUNITY LIVING SKILLS
   With what type of assistance would this person currently be able to:

   Please put appropriate number in the box under the year of assessment.
   (Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

	Date:	Date:	Date:
a.) Prepare simple foods requiring no mixing or cooking?			
b.) Take care of personal belongings, room (excluding vacuuming, ironing, clothes washing/drying, wet mopping)?			
c.) Add coins of various denominations up to one dollar?			
d.) Use telephone to call home, doctor, fire, police?			
e.) Recognize survival signs/words: i.e., stop, go, traffic lights, police, men, women, restrooms, danger, etc.?			
f.) Refrain from exhibiting unacceptable sexual behavior in public?			
g.) Go around cottage, ward, building, without running away, wandering off, or becoming lost?			
h.) Make minor purchases, i.e., candy, soft drinks, etc.?			

Addendum to LOF Survey

Client Name: _____ SSN: _____

Address: _____
(Street) (City) (State) (Zip Code)

Phone: _____Birthdate: _____ Sex: _____

Primary Caregiver: _____

Address: _____

Relationship: _____Phone: _____

Presenting Problem/Diagnosis: _____

Medications: _____

_____

Is the Individual Oriented to:

Person: ____ Place: ____ Time: ____

Describe any problems with caregiving:

Assessment completed by:

Assessor's Name	Signature	Provider Name	Provider Number