agency for persons with disabilities
State of Florida

Home and Community Based Services
Waiver Eligibility Work Sheet

Name: _____ SS#: _____ Area/Region:_____

Support Plan Effective Date: _____

I. Level of Care Eligibility:

The individual is a client of Developmental Disabilities who meets one of the following criteria and is eligible to receive the services provided in an ICF/DD. Check the criteria that are met.

Option A. ___ The individual's primary disability is mental retardation with an intelligence quotient (IQ) of 59 or less.

Option B. ___ The individual's primary disability is mental retardation with an intelligence quotient (IQ) of 60-69 inclusive and the individual has at least one of the following handicapping conditions OR individual's primary disability is mental retardation with an intelligence quotient (IQ) of 60-69 inclusive and the individual has severe functional limitations in at least three of the major life activities. Please check all handicapping conditions and major life activities that apply.

Option C. ___ The individual is eligible under the category of autism, cerebral palsy, Down Syndrome, Prader-Willi syndrome or spina bifida or and the individual has severe functional limitations in at least three of the major life activities. Please check all handicapping conditions and major life activities that apply.

Handicapping Conditions			**Major Life Activities**	
__ Ambulatory Deficits __ Sensory Deficits __ Chronic Health Problems	__ Behavior Problems __ Autism __ Cerebral Palsy __ Down syndrome	__ Epilepsy __ Spina Bifida __ Prader-Willi Syndrome	__ Self Care __ Understanding and use of language __ Learning	__ Mobility __ Self Direction __ Capacity for independent living

II. Medicaid Eligibility:

A. ___ Individual has a current Medicaid number. Medicaid #_____

B. ___ Individual was referred for Medicaid eligibility on _____
Date

The result was: ____ Eligible ____ Ineligible Date of Determination_____

III. Eligibility Determination: Check the correct statement

A. ___ Individual has met Level of Care Eligibility (I), has a Medicaid number (IIA) and is eligible for Waiver Services.

B. ___ Individual has not met the Level of Care Eligibility in I and/or II and, therefore, is not eligible for Waiver Services.

Support Coordinator (Signature):_____ Date:_____

Agency: _____

IV. Choice:

I have received an explanation of home and community-based services and my rights under Chapter 120 F.S. to make an administrative appeal and rights to a fair hearing under Chapter 42 CFR §431.200. I have also received the brochure entitled "Guide to Administrative Hearings".

(CHOOSE ONE OF THE FOLLOWING)

A. ___ I have been offered waiver services and I choose to receive community-based supports and services. I understand that I have a choice of enrolled eligible providers.

B. ___ I choose to receive institutional services and prefer services to be provided in an institutional setting.

Individual : _____ Date:_____

Legal Representative or Witness:_____ Date:_____

Printed name:_____ Relationship:_____