**iBudget Florida HCBS Waiver Eligibility Work Sheet**

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| **Name:** **SS# \*: \_****\_\_\_\_\_\_\_\_\_**  **Region: \_****\_\_\_\_\_\_ Support Plan Effective Date: \_****\_\_\_\_\_\_\_** | | | | |
| 1. **Level of Care Eligibility:**   The individual is an APD client with a Developmental Disability who meets one of the following criteria and is eligible to receive services provided in an ICF/DD. Check the criteria that are met.  Option A.  The individual’s primary disability is Intellectual Disability with an intelligence quotient (IQ) of 59 or less.  Option B.  The individual’s primary disability is Intellectual Disability with an intelligence quotient (IQ) of 60 to 69 inclusive and the individual has at least one of the following handicapping conditions OR the individual’s primary disability is Intellectual Disability with an intelligence quotient (IQ) of 60 to 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, Spina Bifida, or Phelan-McDermid Syndrome 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  Phelan-McDermid Syndrome | 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 |
| **Medicaid Eligibility:** Individual has a current Medicaid number. Medicaid #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  * 1. Individual was referred for Medicaid eligibility on  \_(MM/DD/YY)   The result was: Eligible  Ineligible  Date of Determination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Eligibility Determination:** Check the correct statement:  1. Individual has met Level of Care Eligibility (I), has a Medicaid number (IIA), and is eligible for waiver services.  1. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Choice:**  Only to be completed at the time of initial Waiver enrollment and every 365 days thereafter. I have received an explanation of home and community-based services.**(CHOOSE ONE OF THE FOLLOWING**)  1. 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.  1. I choose to receive institutional services and prefer services to be provided in an institutional setting.   Individual (Signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_  Legal Representative or Witness (Signature):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_  Printed Name of Rep. or Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

\* **Federal law requires the collection of your social security number as a condition of eligibility for Medicaid benefits under 42 U.S.C. 1320b-7 and the agency will collect, use, and release the number for administrative purposes as authorized under law.**