

**ICF/MR Level of Service Certification**

**B.M.S. - 99**

<b>Region: Check One</b>	<b>1:</b>	<b>2A:</b>	<b>2L:</b>	<b>2R:</b>	<b>3B:</b>	<b>3A:</b>
<b>Name:</b>				<b>Date of Birth:</b>		
<b>Address:</b>				<b>Diagnosis:</b>		
<b>Telephone #</b>						
<b>Social Security #</b>				<b>Medicaid #</b>		
<b>Medicare #</b>				<b>Other Insurance</b>		
<b><u>Legal Representative</u></b>	<b><u>Address:</u></b>			<b><u>Telephone #</u></b>	<b><u>Caseworker &amp; Phone #</u></b>	

**Examples of Covered ICF-MR Services**

The following are examples of ICF-MR group home facility services and conditions. Any combination of examples may equate the needs for ICF-MR group home facility services.

1. Independent in mobility or in the use of a wheelchair or other mobility device.
2. May need assistance in personal care such as oral hygiene, care of skin, personal grooming and bathing.
3. May exhibit or has exhibited deviation from acceptable behavior.
4. May require some personal supervision.
5. May require some protection from environmental hazards.
6. Is able to participate, under supervision, in diversional and motivational activities both in the facility and in the community.
7. Is able to participate in one or more developmental, vocational or community programs.
8. Medications ordered by the physician are of a routine nature that can be administered by qualified group home facility personnel.
9. May be aphasic.

**Date consumer planning meeting was held which recommended either ICF-MR or Waiver**

**Level of services: Date: \_\_\_\_\_, Today's Date: \_\_\_\_\_**

**Purpose of this form:  Initial Classification (New)  Reclassification**

**Summary of observed behavior and social history which determined level of need of care, based on examples listed above:**

**Consumer Name:** \_\_\_\_\_

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A= Independent, B= Needs Supervision, C= Needs Skills Training, D= Needs Physical Assistance, E= Total Care

**A.) Activities of Daily Living** (Insert the letter that best applies)

Eating		<b><u>Explain:</u></b>
Dressing		
Toileting		
Bathing		
Grooming		
Mobility		

**B.) Safety**

Avoidance of physical danger		<b><u>Explain:</u></b>
Avoidance of emotional jeopardy		
Engagement in healthy relationships		
Judgment regarding personal conduct		

**C.) Household Activities**

Cooking		<b><u>Explain:</u></b>
Laundry		

**D.) Community Access**

Shopping		<b><u>Explain:</u></b>
Transportation		
Banking		
Recreation		

**E.) Maintain Relationships**

Family		<b><u>Explain:</u></b>
Friends		
Coworkers		
Support Staff		

**F.) Health Maintenance**

Accessing Medical Care		<b><u>Explain:</u></b>
Emergency First-Aid		
Accessing Mental Health Care		
Medication Administration		

**G.) Communication**

Expressive Communications		<b><u>Explain:</u></b>
Receptive Communications		
Sign Language		
Visual/Gestural		

Person Filling Out Form, Name: \_\_\_\_\_, Date: \_\_\_\_\_

Regional Review: \_\_\_\_\_, Date: \_\_\_\_\_

This individual does      does not      meet the standards for ICF-MR or Waiver Level of Services

QMRP Review: \_\_\_\_\_, Today's Date: \_\_\_\_\_, Next Reclass Date: \_\_\_\_\_