State of Illinois
Department of Human Services - Division of Developmental Disabilities

Redetermination of Medicaid DD Waiver Eligibility

Page 1 Summary

Name: _____

Last First Middle

Social Security Number: _____ Recipient I.D. Number: _____

Continuing Individual Eligibility for Medicaid Waiver (check all that apply)

- ☐ Yes, the individual has a diagnosis of mental retardation,
- ☐ Yes, the individual has a diagnosed related condition
  - ☐ It is attributable to epilepsy or cerebral palsy.
  - ☐ It is attributable to _____ (Please specify.)
  - ☐ The individual has substantial functional limitations is three or more of the following major life areas. (check all that apply)
    - ☐ Self-care ☐ Learning ☐ Self-direction
    - ☐ Mobility ☐ Language ☐ Capacity for independent living

☐ Yes, the individual requires active treatment for a developmental disability consistent with the ICF/DD admission criteria defined in the HFS Long Term Care Pre-Admission Screening Rule.

☐ No, the individual does not need active treatment or does not have a developmental disability.

The results of this redetermination must be transmitted to DHS within one month.
Do not submit paper form to DHS unless requested. Maintain in the individual record.

I have personally reviewed the criteria referenced and information about the individual, including a current ICAP or SIB. I certify that the criteria are accurately applied to this individual and that documentation is currently available in the individual's record.

Individual Service and Support Advocate

Signature _____ Printed Name: _____

Telephone: _____ Date of Redetermination: _____

PAS/ISSA Agency: _____

Service Provider Agency: _____

Print Form Reset Form

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Page 2 Documentation

Name: _____

Last First Middle

The following documentation describes the basis for the professional judgment expressed on the front of this form. Further documentation is currently available in the individual record.

Required functional assessment (not more than six months old):

☐ ICAP GMI: _____ Service Score: _____

Date Completed: _____

OR

☐ SIB GMI: _____ Service Score: _____

Date Completed: _____

Diagnoses (including level of mental retardation, related conditions (epilepsy, cerebral palsy, autism, etc.), mental illness, major medical conditions, physical or sensory limiation, as applicable):

Summary Documentation of the need for an ICF/Dd level of care: (Write here and/or attach to this form)

This state agency is requesting disclose of information that is necessary to accomplish the statutory purpose as notified under 20ILCS 1705/15. Non-disclosure of this information may prevent this form from being processed. This form has been approved by the Forms Management Center.

Print Form Reset Form