iBudget Florida HCBS Waiver Eligibility Work Sheet

Name: _______________SS# *: _______________

Region: _____________ Support Plan Effective Date: _______________

I. 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	☐ Behavior Problems	☐ Epilepsy	☐ Self Care	☐ Mobility
☐ Sensory Deficits	☐ Autism	☐ Spina Bifida	☐ Understanding and Use of Language	☐ Self Direction
☐ Chronic Health Problems	☐ Cerebral Palsy	☐ Prader-Willi Syndrome	☐ Learning	☐ Capacity for Independent Living
☐ Phelan-McDermid Syndrome	☐ Down Syndrome			

II. Medicaid Eligibility:

A. ☐ Individual has a current Medicaid number. Medicaid #_______________

B. ☐ Individual was referred for Medicaid eligibility on ___________(MM/DD/YY)

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: 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)

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 (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.**