HOME/COMMUNITY-BASED SERVICES
ELIGIBILITY DETERMINATION FORM

TO BE COMPLETED BY PROVIDER, THEN SENT TO DIVISION OF DEVELOPMENTAL DISABILITIES QDDP/QUALIFIED STAFF

_____

CFCM Provider Phone Number

_____

Applicant's Name Social Security Number Medicaid Number

_____

Address Phone Number

Date of birth_____

Is applicant a recipient of SSI? ☐ **Yes** ☐ **No**

Date the DSS EA 265e or the DSS EA 240 submitted to DSS _____

I. ARE THE FOLLOWING ATTACHED?

1. Current Psychological ☐ **Yes** ☐ **No**

- Completed by a qualified professional
- Diagnosis
- IQ Score
- Adaptive Testing

2. ICAP ☐ **Yes** ☐ **No**

- Include completed ICAP Booklet (must be legible)
- Include completed ICAP Compuscore (3 page summary)
- Include completed ICAP Score Worksheet (DHS-DD-ICAP)

3. Provisional Plan of Care (SCR) ☐ **Yes** ☐ **No**

- If CSP is selected, identify services and signed by both CM and CSP

4. HCBS Waiver Rights (DHS-DD-717) ☐ **Yes** ☐ **No**

- Must be dated on or before the start date

PROVIDER AUTHENTICATION _____

Case Manager Date