Intermediate Care Facility For Individuals With Intellectual Disabilities (ICF/IID) Pre-Admission Team Report And Request For Medicaid Certification

Facility:					
Address:			**Phone:**		
Last Name:	**First Name:**	**MI:**	**Sex:** ☐M ☐F	**DOB**:	**Medicaid #:**
Address:			**Person Presently Lives:** ☐Community Home ☐With Family ☐ ICF/IID ☐ Other:		
QIDP:			**Phone Number:**		
Address:					
Family, Legal Guardian or Responsible Party: Name: Address:			**Phone Number:**		
Admitting Diagnosis:			**Test Results:** Chest X-Ray: ☐ Positive ☐ Negative ☐ N/A TB Test: ☐ Positive ☐ Negative Date:		
Current Medications:	**Dosage**	**Frequency**	**Treatments:**		

These evaluations were utilized in this team conference: (Enclose copies of each)

Psychological Date:	**Social Date:**	**Nutritional Date:**
History and Physical Date:	Other: Date:	Other: Date:
Other: Date:	Other: Date:	Other: Date:

From these evaluations, the person has the following specific needs in areas of major life activity as a result of his/her developmental disability:

Self-Care	**Understanding & Use of Language**	**Learning**
Mobility	**Self-Direction**	**Capacity for Ind. Living**

List the STRENGTHS and PREFERENCES of this Person:

Person will receive: ☐ Physical Therapy ☐Occupational Therapy ☐ Speech Therapy ☐ Audiology ☐ Other Specify:

Can this person's needs be met by alternative services? ☐ Yes ☐ No

If yes, are alternative services available? ☐ Yes ☐ No
Explain:

Initial Continued Stay Review Date:

Team Members:

QIDP:	Physician:	Psychologist:
Social Worker:	Registered Nurse:	Person:
Advocate:	Other:	Other:

Physician's Signature:	Date:

DEPARTMENT OF MENTAL HEALTH USE ONLY:

Approved for ICF/IID placement: ☐ Yes ☐ No Approved by: _____ Date: _____

Reason for Denial:

Signature and Title of Reviewer:	Date: