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GOVERNOR

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SECRETARY

State of Louisiana

Louisiana Department of Health
Office for Citizens with Developmental Disabilities

Dear Physician:

Your client/patient has the opportunity to receive a waiver through the Office for Citizens with Developmental Disabilities. He/she needs your assistance to complete a required part of the eligibility determination process.

The waiver opportunity being provided is a Medicaid home and community-based waiver program. The waiver program allows for assistance in the home, giving some relief to the primary care-giver. The supports and services in waiver programs are targeted to supporting individuals with developmental disabilities to live independently with assistance or to remain in the homes with their families, who would otherwise require institutionalization. Waiver services are delivered in addition to Medicaid State Plan benefits.

Part of the application process is to obtain medical information using the Request for Medical Eligibility Determination Form 90-L. We are requesting your assistance in completing the form to ensure medical eligibility for this individual.

- **Section I** should already have been completed by the individual/family/legal guardian. If not complete, please assist your client/patient in completion.
- **Section II** may be completed by a Nurse, Nurse Practitioner, or Physician Assistant.
- **Section III** may be completed by Nurse, Nurse Practitioner, or Physician Assistant.
- **Section III, I,** Physician's signature, **MUST** reflect your signature, unless otherwise allowed as noted on the form (i.e., individuals receiving the NOW can have a Nurse Practitioner or Physician Assistant signature). In all cases, your printed name and address must be listed on the form.

Section I, part F, should note that the individual is applying for intellectual and developmental (ID) disabilities services. To be eligible to receive home and community based services, a person must meet the ICF/ID level of care. Information describing level of care is on the reverse side of this page. Your completion of the 90-L form is integral in our determination of whether or not your client/patient meets ICF/ID level of care.

Once completed, signed and dated, the 90-L form is time-sensitive. The individual/family/legal guardian should promptly return the completed 90-L form to the support coordination agency responsible for coordinating the waiver services.

Thank you for your time and assistance in this matter. If you have any questions, please feel free to contact 1-866-783-5553.

FACT SHEET FOR LEVEL OF CARE: MEDICAID ELIGIBILITY DETERMINATION
FORM 90-L

In order to qualify for Centers for Medicare and Medicaid Services (CMS) Home and Community-Based Waiver services, a person must meet the definition for an intellectual or developmental disability AND the requirements for an Intermediate Care Facility for Persons with Intellectual or Developmental disabilities (ICF/ID) level of care, which requires active treatment of a developmental disability under the supervision of a qualified developmental disability professional. The Definition of a developmental disability is provided in this fact sheet.

Checking the "ICF/ID" level of care on the Medical Eligibility Determination form 90-L does not always mean the person has to have a diagnosis of developmental disability, nor does it mean that the person currently requires the services of a group home or supports and services center.

CMS specifies that 'in order for an individual to be considered to require a level of care specified for the waiver, it must be determined that: a)the person requires at least one waiver service, and b) requires the provision of waivers services at least monthly to assure health and welfare. Entrance to the waiver is contingent on a person's requiring one or more of the services offered in the waiver in order to avoid institutionalization.

A developmental disability as defined by The Developmental Disability Law, Louisiana Revised Statutes 28:451.1-455.2, is as follows:

"Developmental Disability" means either:

(a) A severe chronic disability of a person that:

(i) Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments.

(ii) Is manifested before the person reaches age twenty-two.

(iii) Is likely to continue indefinitely.

(iv) Results in substantial functional limitation in three or more of the following areas of major life activity:

(aa) Self-care.

(bb) Receptive and expressive language.

(cc) Learning.

(dd) Mobility.

(ee) Self-direction.

(ff) Capacity for independent living.

(gg) Economic Self-sufficiency.

(v) Is not attributable solely to mental illness.

(vi) Reflects the person's need for a combination and sequence of special interdisciplinary or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

(b) A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine which, without services and support, has a high probability of resulting in those criteria in Subparagraph (a) of this Paragraph later in life that may be considered a developmental disability.

If you have any concerns or questions about the Medical Eligibility Determination Form 90-L and Level of Care, do not hesitate to contact the Office for Citizens with Developmental Disabilities at 1-866-783-5553 Monday through Friday from 8 am to 4:30 pm.

OCDD Form 90-L
Rev. 06/01/2017

REQUEST FOR MEDICAL ELIGIBILITY DETERMINATION
Intellectual/Developmental Disability Level of Care

I. RECIPIENT INFORMATION

A. Recipient's Name:		**SS #:**	**Medicaid #:**
B. Address (City, State, Zip Code, Parish):		**C. Responsible Party/Curator:**	
		Address (City, State, Zip Code, Parish):	
Telephone #:	**Sex:** ☐ M ☐ F		
Medicare #:	**Date of Birth:**	**Relationship:**	**Telephone #:**

D. What are/were the living arrangements: ☐ Own home ☐ Relative's home ☐ Other:_____

E. What previous facility care has this person received?

Facility:	**Date:**	**Facility:**	**Date:**
Facility:	**Date:**	**Facility:**	**Date:**

F. What Home/Community-based services have been used/considered:
☐ NOW ☐ CC ☐ Supports ☐ ROW ☐ Other:_____

G. Applicant/Responsible Party Signature:_____ **Date:**_____

II. LEVEL OF CARE

The attending physician (/designee for NOW) must approve the required level of care:

A. ☐ **ICF/ID - Requires active treatment of developmental disability under supervision of a qualified intellectual / developmental disability professional.**

B. ☐ **Skilled Care (maximum care required) – Indicate special level, if needed:** ☐ TDC ☐ ID ☐ NRTP (☐ Complex; ☐ Rehab)
Includes professional nursing care and assessment on a daily basis due to a serious condition which is unstable or a rehabilitative therapeutic regime requiring professional staff.

C. Are Home/Community Based Services adequate to meet the needs of this patient? ☐ Yes ☐ No

D. COMMENTS:

III. MEDICAL INFORMATION

A. Diagnosis:_____

B. Medications:(Specify dosage, frequency, and route) ALLERGIES_____

1. _____	5. _____	9. _____
2. _____	6. _____	10. _____
3. _____	7. _____	11. _____
4. _____	8. _____	12. _____

Recipient's Name:

C. Recent Hospitalizations: _____

D. Mental Status/Behavior: check Yes or No. If Yes, indicate frequency: 1 = seldom; 2 = frequent; 3 = always

☐Yes (1, 2, 3) ☐No 1. Oriented	☐Yes (1, 2, 3) ☐No 4. Comatose	☐Yes (1, 2, 3) ☐No 7. Hostile
☐Yes (1, 2, 3) ☐No 2. Forgetful	☐Yes (1, 2, 3) ☐No 5. Confused	☐Yes (1, 2, 3) ☐No 8. Combative
☐Yes (1, 2, 3) ☐No 3. Depressed	☐Yes (1, 2, 3) ☐No 6. Wanders	

E. Communications: ☐Verbal ☐Non-verbal

F. Activities of Daily Living: (check appropriate box)

SELF	ASSIST	TOTAL	
☐	☐	☐	1. Eating
☐	☐	☐	2. Bathing
☐	☐	☐	3. Personal
☐	☐	☐	4. Ambulation
☐	☐	☐	5. Transfer
☐	☐	☐	6. Bowel Incontinence
☐	☐	☐	7. Bladder Incontinence
☐	☐	☐	8. Urinary Catheter

☐ 9. Impaired vision _____
☐ Glasses

☐ 10. Impaired hearing _____
☐ Hearing Aid

☐ 11. Dentures _____

G. SPECIAL CARE/PROCEDURES: (check appropriate box: when appropriate give type, frequency, size, stage and site)

☐ 1. Ostomy care _____
☐ 2. Glucose Monitoring _____
☐ 3. Restraints _____
☐ 4. IV's _____
☐ 5. Suctioning _____
☐ 6. Specialized Rehab _____
☐ 7. MRSA/Infections _____
☐ 8. Diet/Tube Feeding _____
☐ 9. Dialysis _____
☐ 10. Respiratory _____
☐ 11. Wound Care/Decubitus _____
☐ 12. Tracheostomy Care _____
☐ 13. Ventilator Dependent _____
☐ 14. Other _____

H. PHYSICAL EXAMINATION: Height_____Weight_____Pulse_____Resp_____Temp_____B/P_____

Lab Results: HCT_____HGB_____U/A_____ Radiology_____
General_____ Head and CNS_____
Mouth and EENT_____ Chest_____
Heart and Circulation_____ Abdomen_____
Genitalia_____ Extremities_____
Skin_____ Other_____

I. MD Signature is required EXCEPT for the NOW program. The NOW can have a Nurse Practitioner/Physician Assistant signature.

In all cases a supervising physician must be identified.

Physician's Name (print):_____ Phone:_____

Address:_____

Nurse Practitioner/Physician Assistant Name (print):_____

Physician/Nurse Practitioner/Physician Assistant Signature:_____

(Signer please identify profession/credentials)

OCDD FORM 90-L
REQUEST FOR MEDICAL ELIGIBILITY DETERMINATION
ADDITIONAL INFORMATION FOR COMPLETION

Section Name	Who Completes	Item(s)	Instruction/Additional Information
I. Recipient Information	The person or the parent/legal guardian/authorized representative of the person requesting waiver services	A. & B.	This information is about the person.
		C.	This information is about the parent/legal guardian/ authorized representative.
		D., E., F.	This information is about the person.
		G	The person requesting waiver services or the parent/legal guardian/authorized representative must sign and date.
II. Level of Care Determination	Physician/Nurse Practitioner/Physician's Assistant/Nurse	A. or B.	The individual must meet the Definition for a developmental disability and requirements for an ICF/ID **level of care**. In order to qualify for home and community-based services (waiver), the level of care must be identified as "ICF/ID – Requires active treatment of an intellectual or developmental disability under supervision of a qualified mental retardation or developmental disability professional. Please refer to the fact sheet for further information. Please check the appropriate level of care. **ONLY ONE LEVEL OF CARE IS TO BE CHECKED.**
		C.	Are home and community based-services adequate to meet the needs of the participant? Check appropriate response.
		D.	Add any applicable additional comments/information.
III. Medical Information	Physician/Nurse Practitioner/Physician's Assistant/Nurse	A.	A diagnosis must be present.
		B.	Medications must be identified including dosage and frequency.
		C., D. & E.	Complete as it applies to the person/patient.
		F.	Please check the appropriate level of support required for ADLs.
		G.	Please check all appropriate special care/procedures information and include type, frequency, size, stage and site.
		H.	Physical examination must be completed.
		I.	**Must be signed and dated by physician.** Form may be completed by a Nurse Practitioner or Physician's Assistant, however, it must be **SIGNED BY THE PHYSICIAN unless otherwise noted.** For individuals in the New Opportunities Waiver, the Nurse Practitioner or Physician Assistant may sign the form. In all cases, the Physician's printed name, practice address and phone number must be identified on the form.