QMRP CERTIFICATION FOR ICF/MR LEVEL OF CARE WAIVER

State Form 51036 (10-02) / OMPP 450B/QMRP

Indiana Family and Social Services Administration (IFSSA)

CONFIDENTIAL

ASSESSMENT TYPE	MEDICAID STATUS
☐ Initial Assessment	☐ Medicaid Pending
☐ Re-Screening	☐ Medicaid Recipient

Name of contact:	Upon completion return to: ☐ Area agency ☐ Other: _____ ☐ Bureau of Developmental Disability Services

I - RECIPIENT IDENTIFICATION

Name of applicant: *(last, first, middle)*	Date of birth: *(mo., day, yr.)*	Name of county:
Name of nursing facility or ICF / MR *(if applicable)*:	Sex:	Medicaid number:
Address: *(street and number)*		
City, state and zip code:		

II - MEDICAL SUMMARY

Fedral and state regulations require a physician's **physical examination***, plan of treatment and recommendations for care prior to admission or continued care in the Medicaid Home and Community-Based Waiver program. Check all applicable boxes below and attach current *(within past year)* medical documentation *(Physician's medical records, hospital discharge summary, facility chart records, etc.)* to support each item checked.

☐ Ambulatory	☐ Contractures	☐ Colostomy / Ileostomy	☐ Self Fed
☐ Wheelchair	☐ Incontinent *(bladder)*	☐ Other Ostomy	☐ I.V. Fluids / Nutrition
☐ Cane or Walker	☐ Incontinent *(bowell)*	☐ Aphasic	☐ Tube Fed - Type _____
☐ Bedfast	☐ Catheter _____	☐ Agitated / Combative	☐ Decubiti (size, stage, treatment)
☐ Ventilator Dependant	☐ Tracheotomy	☐ Confused / Disoriented	☐ Other _____

Primary diagnosis *(include dates)*	Secondary / tetiary diagnosis *(include dates)*

*** ATTACH copy of current *(within past year)* PHYSICAL EXAMINATION by physician (MD or DO) may also attach Form 450B - Section VI "Physician Examination".**

List medications: *(attach documentation verifying medications, dosage and frequency)*

QMRP LEVEL OF CARE RECOMMENDATION / COMMUNITY CERTIFICATION

Level of care recommended:

☐ Medicaid Home and Community Based Waiver service ☐ ICF/MR - Level of Care ☐ Other: _____

I certify that community supported in-home care is ☐ safe and feasible ☐ not safe or feasible in regard to health and safety of this patient. If not safe or feasible, explain.

Signature of QMRP *(stamps are NOT acceptable)*	Date signed *(month, day, year)*	Typed or printed name of QMRP

III - LEVEL OF CARE AUTHORIZATION

This certification is for: ☐ Initial ☐ Update ☐ Annual

☐ Approved ☐ Disapproved

Effective Medicaid reimbursement date

Comments

Authorized signature ☐ OMPP ☐ Area agency ☐ Other **QMRP** _____

Date signed *(month, day, year)*

DISCLOSURE STATEMENT

The personal information requested on this form will be used in the determination of your entitlement to or continued receipt of public assistance and/or services administered by the State of Indiana. Disclosure of the information requested is mandatory pursuant to the provision of IC 12-15-2 *et. seq. (Medicaid Programs)*. Non-disclosure of the information requested will hamper and possibly prevent the delivery of assistance or services to you. All personal information collected on this form willl be treated as confidential pursuant to Regulation 470 IAC 1-3-1.