Interim ICF/IID Level of Care Information

To be completed by the participant's Care Coordinator

Participant (Last, First) _____ Date form submitted: _____

D.O.B. _____ Medicaid #: _____ IDD Waiver ◯ ISW Waiver ◯

Plan of Care Start Date: _____ TEFRA ◯ CFC ◯

1. At the time of the last ICAP was the participant living in, or within three months of discharge from, an institution, (skilled nursing facility, rehabilitation center, ICF/IID) correctional facility (jail, halfway house) or other long-term care facility? Yes ☐ No ☐

   Name of facility: _____ Discharge date: _____

2. Primary diagnosis: _____ Secondary diagnosis: _____

3. Have there been significant changes in the participant's behavior or health in the last year? Yes ◯ No ◯

   Explain and attach supporting documentation to detail significant changes that may influence the qualifying diagnosis or change the level of services needed by the participant.

☐ *Qualifying Diagnosis Certification* form attached
The form must be completed by a qualified professional within the previous 12 months certifying that the participant continues to meet the diagnostic criteria for their qualifying diagnosis

Primary physician: _____ Phone: _____ Fax: _____

Address (Street, City, State, ZIP): _____

Care Coordinator: _____ Phone: _____ Email: _____

Agency: _____

E-Mail completed packets through DSM to Sds.iddanchorage@hss.soa.directak.net or
Fax completed forms and documentation to the Senior and Disabilities Services IDD Unit at (907) 269-3639