

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 , unless delegated by the physician to a Nurse Practitioner or Physician's Assistant under his/her supervision for OCDD waiver services . Forms completed for ICF/DD placement still require the physician's signature. In all cases, the Physician's printed name, practice address and phone number must be identified on the form.