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.