

**SENIOR AND DISABILITIES SERVICES
MATERIAL IMPROVEMENT REPORTING
FOR IDD PARTICIPANTS AGE THREE OR OVER**

Client Name:

Medicaid Number:

Date of Current review

DSDID#

Name of Assessor:

ICF/MR Level of Care Factors	Previous CAT (Admitting to waiver) Date/Yr	YES	NO	CURRENT Yr LOC Date/Yr	YES	NO	Material Improvement & Comments
ICAP results							
Evaluations (Psychological, Psychiatric, School eligibility reports, Physical, Occupational, Speech therapy)							
Behavior Support plan (when applicable)							
Medical records							
Qualifying Diagnosis							

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Review Comments:

QMRP Review Note: If the client does not rise to the level of institutional care, please state enter a statement about PCA services and whether this service will adequately meet the client's needs.

(Date)

(Signature or Electronic Signature of QMRP Assessor)

(Printed Name of QMRP Assessor)

(Date)

(Signature of Reviewing QMRP)

(Printed Name of Reviewing QMRP)