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)