



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

TEFRA

Plan of Care Start Date:

- 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:

- Primary diagnosis:

Secondary diagnosis:

- 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