ICF/ID ELIGIBILITY & LOC ASSESSMENT

Reference Manual (Sections A–Q + Indiana Supplemental + Non-interRAI)

Assessment Reference Date:	
Prepared For:	_____
Prepared By:	_____

This manual is designed as a pass-out reference sheet for staff and stakeholders. All response options are intentionally left blank (open bubbles/boxes) for use during completion.

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ICF/ID ELIGIBILITY - NON-interRAI QUESTIONS

Type of Assessment: _____

Service Setting: _____

1. Does the individual have a diagnosis of any of the following:

Intellectual Disability	○ No ○ Yes
Epilepsy	○ No ○ Yes
Cerebral Palsy	○ No ○ Yes
Autism	○ No ○ Yes
Other related condition resulting in functioning similar to Intellectual Disability	○ No ○ Yes

Comments on condition(s):

_____
_____
_____

2. Was/were the condition(s) referenced in question 1 manifested prior to age 22 years?
○ No ○ Yes

3. Is/are the condition(s) referenced in question 1 likely to continue indefinitely?
○ No ○ Yes

SECTION A - Identification Information

Personal Information

1. Legal Name (Last, First, MI, Suffix): _____
2. Sex: _____
3. Birthdate: _____
4. Marital Status: _____

Billing Details

5. Social Security Number: _____
Medicare Number: _____
Medicaid Number (+ if pending; N if not recipient): _____
6. Provider Number: _____

Payment Information

Medicaid	○ No ○ Yes
Medicare	○ No ○ Yes
Self or family pays for full cost	○ No ○ Yes
Medicare with Medicaid co-payment	○ No ○ Yes
Private insurance	○ No ○ Yes
Other per diem	○ No ○ Yes

Reason for Assessment

8. Reason for Assessment: _____
9. Assessment Reference Date:

Goals

10. Person's Expressed Goals: _____
Primary Goal: _____

Responsibility / Legal Guardian

Legal guardian	○ No ○ Yes
Other legal oversight	○ No ○ Yes
Durable power of attorney (health care)	○ No ○ Yes
Durable power of attorney (financial)	○ No ○ Yes

Family member responsible	○ No ○ Yes
Person responsible for self	○ No ○ Yes

Living Arrangements

12. Admitted from: _____
Usual Residential Status: _____
13. Postal / Zip Code of usual living arrangement: 46614
14. Living Arrangement: _____

SECTION B - Intake and Initial History (Complete at Admission / First Assessment Only)

1. Date Case Opened:

2. Ethnicity and Race

Hispanic or Latino	○ No ○ Yes
American Indian or Alaska Native	○ No ○ Yes
Asian	○ No ○ Yes
Black or African American	○ No ○ Yes
Native Hawaiian or other Pacific Islander	○ No ○ Yes
White	○ No ○ Yes

3. Primary Language: _____
4. Nature of Intellectual Disability: _____
5. Documented Severity of Intellectual Disability: _____
6. Age at which person left family home (88=not applicable; 99=unknown):
_____
7. Number of years (lifetime) in institutional setting (0=never; 99=unknown):
_____

8. Residential History over last 5 years (Code all settings lived in during 5 years prior to date case opened)

Semi-independent living (SIL)	○ No ○ Yes
Board and care	○ No ○ Yes
Group home	○ No ○ Yes
Institutional setting for persons with intellectual disability	○ No ○ Yes

SECTION C - Community and Social Involvement

1. Employment Status: _____
2. Employment Arrangements (Exclude volunteering):

_____

3. Involvement in Structured Activities

Formal education program	○ No ○ Yes
Volunteerism (e.g., community services)	○ No ○ Yes
Day program	○ No ○ Yes

4. Number of days of participation in preferred recreation/leisure in last 7 days:

_____

5. Sense of Involvement (describe)

_____

_____

6. Person Prefers Change (When asked)

☐ Paid employment (type, hours, pay)
☐ Recreational activities (type, number/level of participation)
☐ Living arrangements (location, type, who lives with)
☐ Daily routine (diet, sleep schedule, clothes to wear)
☐ Supports and services (programs, staff)
☐ Relationships (friendships / improving relationships)

SECTION D - Strengths, Relationships, and Supports

1. Strengths

Consistent positive outlook	○ No ○ Yes
Finds meaning in day-to-day life	○ No ○ Yes
Reports having a confidant	○ No ○ Yes
Strong and supportive relationship with family	○ No ○ Yes
Reports strong sense of involvement in community	○ No ○ Yes

2. Social Relationships (whenever possible, ask person)

☐ Participation in social activities of long-standing interest
☐ Visit with a long-standing social relation or family member
☐ Other interaction with long-standing social relation/family (phone, email)
☐ Overnight stay (1+ nights) at home of family/long-standing relation

3. Unsettled Relationships

Conflict with or repeated criticism of family or friends	○ No ○ Yes
Conflict with or repeated criticism of other clients	○ No ○ Yes
Conflict with or repeated criticism of staff	○ No ○ Yes
Family/close friends persistently hostile toward person	○ No ○ Yes

4. Two Key Supports

Helper 1 - Relationship to person: _____
Areas of unpaid support during last 3 days:
☐ General oversight/cueing ☐ IADL ☐ ADL ☐ Crisis support ☐ Social inclusion ☐ Companionship

Helper 2 - Relationship to person: _____
Areas of unpaid support during last 3 days:
☐ General oversight/cueing ☐ IADL ☐ ADL ☐ Crisis support ☐ Social inclusion ☐ Companionship

5. Support Given to Others (exclude volunteer and paid activities)

Companionship	○ No ○ Yes
IADL	○ No ○ Yes

ADL	○ No ○ Yes

6. Total hours of unpaid support and active monitoring during LAST 3 DAYS:
_____

7. Status of Supports (exclude paid help)

Support person(s) unable to continue in caring activities	○ No ○ Yes
Primary support person expresses distress/anger/depression	○ No ○ Yes
Family/close friends report feeling overwhelmed	○ No ○ Yes

8. Plans for future needs

_____
_____

9-10. Life Events

Code for most recent time of event (if applicable):
☐ Serious accident or physical impairment
☐ Distress about health of another person
☐ Death of close family member or friend
☐ Victim of sexual assault or abuse
☐ Victim of physical assault or abuse
☐ Victim of emotional abuse
☐ Victim of bullying

10. Describes one or more of these life events as invoking a sense of horror or intense fear
○ No ○ Yes

SECTION E - Lifestyle

1. Caffeine use - highest # caffeinated beverages in any single day of LAST 3 DAYS:
_____
2. Smokes Tobacco Daily: ○ No ○ Yes
3. Alcohol - highest # drinks in any single sitting in LAST 14 DAYS:
_____
4. Total hours of exercise/physical activity in LAST 3 DAYS:
_____

SECTION F - Environmental Assessment (Home Environment)

Code any of the following that make home environment hazardous or uninhabitable (if temporarily in institution, base on home visit):

☐ Disrepair of the home (hazardous clutter; inadequate/no lighting; holes in floor; leaking pipes)
☐ Squalid condition (extremely dirty; infestation by rats/bugs)
☐ Inadequate heating or cooling (too hot in summer; too cold in winter)
☐ Lack of personal safety (fear of violence; safety issue going to mailbox; heavy traffic)
☐ Limited access to home/rooms (difficulty entering/leaving; stairs; maneuvering; no railings although needed)

SECTION G - Communication and Vision

1. Communication methods - primary expressive communication: _____
2. Making self understood (expression): _____
3. Ability to understand others (comprehension): _____
4. Hearing (with hearing appliance normally used): _____
5. Vision (with glasses/visual appliance normally used): _____

SECTION H - Cognition

1. Cognitive skills for daily decision making: _____

2. Memory / Recall Ability

☐ Short-term memory OK (recalls after ~5 minutes)
☐ Procedural memory OK (multi-task sequence without cues)
☐ Situational memory OK (recognizes caregivers and knows regular locations)

3. Periodic disordered thinking or awareness (last 3 days)

☐ Easily distracted
☐ Episodes of disorganized speech
☐ Mental function varies over the course of the day

4. Acute change in mental status from person's usual functioning
○ No ○ Yes

5. Change in decision making compared to 90 days ago (or since last assessment):
_____

SECTION I - Health Conditions

1. Self-reported health (ask: 'In general, how would you rate your health?'):
_____

2. Problem frequency (presence in last 3 days)

Balance (a-d)

☐ Difficult/unable to move to standing unassisted
☐ Difficult/unable to turn and face opposite direction when standing
☐ Dizziness
☐ Unsteady gait

Psychiatric (e-g)

☐ Abnormal thought process
☐ Delusions
☐ Hallucinations

GI Status (h-n)

☐ Acid reflux ☐ Constipation ☐ Diarrhea ☐ Dry mouth ☐ Hypersalivation/drooling
☐ Increase/decrease in appetite ☐ Vomiting

Other Conditions (o-s)

☐ Aspiration ☐ Daytime drowsiness/sedation ☐ Headache ☐ Peripheral edema ☐ Seizures

3. Dyspnea (shortness of breath): _____
4. Fatigue (inability to complete normal daily activities): _____

5. Extrapyramidal symptoms during last 3 days

Akathisia ○ No ○ Yes
Dyskinesia ○ No ○ Yes
Tremor ○ No ○ Yes
Bradykinesia ○ No ○ Yes
Rigidity ○ No ○ Yes
Dystonia ○ No ○ Yes
Slow shuffling gait ○ No ○ Yes

6. Falls (details or count): _____

7. Pain Symptoms (always ask person about pain frequency, intensity, and control)
Frequency person complains/shows evidence of pain:
_____
Intensity of highest level of pain present: _____
Consistency of pain: _____

Pain control adequacy (from person's point of view): _____

8. Scheduled toileting ○ No ○ Yes
9. Bladder continence: _____
10. Bowel continence: _____
11. Most severe pressure ulcer: _____

Skin Conditions

12. Presence of skin ulcer other than pressure ulcer ○ No ○ Yes
13. Major skin problems ○ No ○ Yes
14. Other skin conditions/changes ○ No ○ Yes
15. Foot problems ○ No ○ Yes

SECTION J - Independence in Everyday Activities

IADL Self-Performance and Capacity: Code PERFORMANCE in routine activities during LAST 3 DAYS. Code CAPACITY based on presumed ability.

Area	Performance	Capacity
Meal preparation	Performance: ____	Capacity: ____
Ordinary housework	Performance: ____	Capacity: ____
Managing finances	Performance: ____	Capacity: ____
Managing medications	Performance: ____	Capacity: ____
Phone use	Performance: ____	Capacity: ____
Stairs (full flight)	Performance: ____	Capacity: ____
Shopping (exclude transportation)	Performance: ____	Capacity: ____
Transportation (public/driving)	Performance: ____	Capacity: ____

Work (job-related activities; exclude transportation)

Performance: ____ Capacity: ____

ADL Self-Performance

☐ Bathing (exclude washing of back and hair) Score: ____
☐ Personal hygiene (exclude baths and showers) Score: ____
☐ Dressing upper body Score: ____
☐ Dressing lower body Score: ____
☐ Walking (same floor indoors) Score: ____
☐ Locomotion (walking/wheeling) Score: ____
☐ Transfer toilet Score: ____
☐ Toilet use (exclude transfer on/off toilet) Score: ____
☐ Bed mobility Score: ____
☐ Eating Score: ____

4. Primary mode of locomotion: _____
5. Distance wheeled self (farthest in last 3 days): _____
6. Physically restrained ○ No ○ Yes

7. Physical function improvement potential

Person believes capable of improved physical function ○ No ○ Yes
Care professional believes capable of improved physical function ○ No ○ Yes

8. Change in ADL status compared to 90 days ago (or since last assessment):
_____

SECTION K - Oral and Nutritional Status

1. Height and Weight (most recent measure in last 30 days)

Height (in): _____ Weight (lbs): _____

2. Nutritional Issues

Weight loss (5%+ in last 30 days or 10%+ in last 180 days)	○ No ○ Yes
Weight gain (5%+ in last 30 days or 10%+ in last 180 days)	○ No ○ Yes
Fluid intake less than 1,000 cc/day	○ No ○ Yes

3. Chewing problem ○ No ○ Yes
4. Mode of nutritional intake: _____

5. Dental or Oral

Wears a denture (removable prosthesis) ○ No ○ Yes
Has broken/loose/non-intact natural teeth ○ No ○ Yes
Gum inflammation/bleeding adjacent to natural teeth ○ No ○ Yes

SECTION L - Mood and Behavior

Indicators observed in last 3 days (ask person whenever possible).

1. Mood (a-j)

☐ Cheerful, happy facial expressions
☐ Sad, pained, or worried facial expressions
☐ Crying, tearfulness
☐ Made positive statements
☐ Made negative statements
☐ Hyperarousal
☐ Irritability
☐ Pressured speech or racing thoughts
☐ Labile affect
☐ Flat or blunted affect

Anxiety (k-o)

☐ Repetitive anxious complaints/concerns (non-health related)
☐ Unrealistic fears
☐ Obsessive thoughts
☐ Compulsive behavior
☐ Episodes of panic

Negative Symptoms (p-s)

☐ Anhedonia (lack of pleasure)
☐ Withdrawal from activities of interest
☐ Lack of motivation
☐ Reduced social interactions

Other Indicators (t-z)

☐ Repetitive health complaints
☐ Recurrent statements something terrible is about to happen
☐ Persistent anger with self or others
☐ Unusual/abnormal physical movements
☐ Hygiene unusually poor
☐ Difficulty falling asleep or staying asleep
☐ Too much sleep

2. Self-Reported Mood (last 3 days)

Little interest or pleasure in things you normally enjoy? _____
Anxious, restless, or uneasy? _____
Sad, depressed, or hopeless? _____

3. Adjusted easily to changes in routines in last 30 days
○ No ○ Yes

4. Behavioral Symptoms

☐ Wandering
☐ Verbal abuse
☐ Physical abuse
☐ Socially inappropriate/disruptive behavior
☐ Inappropriate public sexual behavior or public disrobing
☐ Resists care
☐ Self-injurious behavior
☐ Destructive behavior
☐ Outburst of anger
☐ Echolalia
☐ Self-talk
☐ Pica
☐ Rumination
☐ Polydipsia

5. Violence (most recent instance)

☐ Intimidation of others or threatened violence
☐ Violence to others

6. Extreme Behavior Disturbance (history suggesting serious risk of harm)
○ No ○ Yes

SECTION M - Medications

1. List of medications (active prescriptions and any OTC taken in last 3 days)

_____
_____
_____

2. Allergy to any drug ○ No ○ Yes
3. Physician reviewed medications as a whole list in last 180 days (or since last assessment) ○ No ○ Yes
4. Adherent with medications prescribed by physician ○ No ○ Yes

SECTION N - Supports and Services

1. Prevention

Complete physical exam in last year	○ No ○ Yes
Dental exam in last year	○ No ○ Yes
Eye exam in last year	○ No ○ Yes
Hearing exam in last 2 years	○ No ○ Yes
Immunizations up-to-date	○ No ○ Yes
Influenza vaccine in last year	○ No ○ Yes

2. Formal Service Providers (paid provider contact in last 30 days)
☐ Developmental services worker or direct care staff
☐ Occupational therapist / physical therapist / speech therapist
☐ Recreation therapist
☐ Nurse

3. Focus of Supports (major focus in last 30 days)

☐ Self-care skills ☐ Community skills ☐ Social skills ☐ Cognitive skills
☐ Education on special topics ☐ Behavior management ☐ Sensory stimulation

4. Hospital / ER / Visits (last 90 days or since admission)

In-patient acute hospital with overnight stay (#): _____
Emergency room visit (#): _____
Visit with physician (#): _____
Visit with licensed mental health professional (#): _____

5. Time since last hospital stay (most recent in last 90 days): _____
6. Number of lifetime psychiatric hospital/unit admissions: _____

SECTION O - Diagnostic Information

1. Medical Diagnoses

☐ Asthma ☐ Cerebral palsy ☐ Diabetes mellitus ☐ Epilepsy/seizure disorder
☐ Hypothyroidism ☐ Traumatic brain injury

2. Mental Health Diagnosis by Category

Delirium, dementia, and amnestic and other cognitive disorders	○ No ○ Yes
Schizophrenia and other psychotic disorders	○ No ○ Yes
Mood disorder	○ No ○ Yes
Anxiety disorder	○ No ○ Yes

SECTION P - Discharge Information (Optional)

1. Last day of involvement with program or agency: _____
2. Discharged to: _____

INDIANA SUPPLEMENTAL QUESTIONS

Learning

☐ Requires training methods that are substantially different (intensity/type/interaction)
☐ Requires a substantially longer time than the general population to learn a basic skill
☐ Does not have basic daily living skills or requires continuous/aggressive training to maintain those skills
☐ Has learned a skill in one setting but cannot utilize that skill in a similar setting without structured support

Exceptional Behavior Needs

Exceptional behavioral needs: Does this individual require exceptional support for any behavioral challenges?
(Defined as constant observation and availability of dedicated 1:1 (or more) assistance to prevent or mitigate harmful behavior.)
○ No ○ Yes

Exceptional Medical Needs

Exceptional medical needs: Does this individual require exceptional support for a medical condition?
(Defined as direct 1:1 assistance for medical care related to medical condition(s).)
○ No ○ Yes

SECTION Q - Assessment Information

1. Signature of person coordinating/completing the assessment: _____
2. Date assessment signed as complete: _____