

LEVEL OF CARE DETERMINATION: PCA AND ABI WAIVER PROGRAMS

Name of Applicant: _____

SECTION I To Be Completed for PCA and ABI Waivers

ADL's	Requires Physical Assistance (PCA/ABI)	Requires Supervision/Cueing (ABI only)
Bathing	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>
Transfer	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>
Feeding	<input type="checkbox"/>	<input type="checkbox"/>
Total	_____	_____

Note: For PCA Waiver, 2 or more ADL's needing physical assistance required to meet NF level of care.

SECTION II To Be Completed For ABI WAIVER ONLY (Applicant must have an Acquired Brain Injury)

Check Applicable Category	Requires
<input type="checkbox"/> Category I (NF):	<ul style="list-style-type: none"> • 2 ADL's (due to physical and/or cognitive deficits) • Impaired Cognition
<input type="checkbox"/> Category II (ABI/NF):	<ul style="list-style-type: none"> • Impaired Behavior (requiring daily supervision) or Cueing • Impaired Cognition • Mental Illness (pre morbid) • and/or currently in ABI specific facility
<input type="checkbox"/> Category III (ICF/MR):	<ul style="list-style-type: none"> • 2 ADL's (due to physical deficits) • Age of Injury Before 22 • Impaired Cognition
<input type="checkbox"/> Category IV (Chronic Disease Hospital)	<ul style="list-style-type: none"> • 2 ADL's (due to physical and/or cognitive deficits) • Impaired Behavior • Impaired Cognition

SECTION III To Be Completed for PCA and ABI Waivers

Level of Care: NF ABI/NF ICF/MR Chronic Disease

DSS Recommendation:

Refer to ABI Waiver Program: Category I II III IV

Refer to PCA Waiver Program: Number of ADL's Requiring Physical Assistance: _____

Comments:

DSS Social Worker: _____

Date: _____

Supervisor: _____

Date: _____

Waiver Coordinator Designee: _____

Date: _____