TEXAS
Health and Human Services

Form 8578
February 2012-E

CLASS, DBMD, HCS, ICF/ID, TxHmL

Intellectual Disability/Related Condition Assessment

1. Facility/Provider Name			2. Contract No.
3. Mailing Address			
4. Name (Last/First/Middle)			
5. Applicant's Address (Street or P.O. Box, City, State, Zip)			
6. Component Code	7. Case No.	8. Medicaid No.	73. CARE ID
9. HIC/Medicare No.	10. Date of Birth (MM-DD-YY)	11. Social Security No.	
12. Date Completed (MM-DD-YY)	13. Purpose Code	14. Date of Physical Examination (MM-DD-YY)	15. Legal Status
16. Previous Residence	17. Recommended LOC	18. Recommended LON	

Diagnosis

19. Primary Diagnosis	20. Code	21. Version Code	22. Onset (MM-YYYY)	
23. Medical Diagnosis/DBMD Second Condition		24. Code	25. Version Code	
26. Psychiatric Diagnosis/Additional Diagnosis(es)		27. Code	28. Version Code	
Cognitive/Adaptive Functioning	29. IQ	68. IQ Instrument	30. ABL	69. ABL Instrument

For CLASS and DBMD use only

70. ABL Assessment Date	71. Level of Consciousness
74. Score Identified by ABL Instrument	75. Functional Assessment

ICAP Data

31. Broad Independence	32. General Maladaptive	33. ICAP Service Level

Behavioral Status

34. Behavior Program	35. Self-Injurious Behavior	36. Serious Disruptive Behavior
37. Aggressive Behavior	38. Sexually Aggressive Behavior	

Nursing

39. Service Provider	40. Frequency Code

Day Service

41. Service	42. Frequency Code	43. Funding Code

Employment Services

44. Service	45. Frequency Code	46. Funding Code

Functional Assessment

47. Ambulation

Individual's Name	Medicaid No.

Physician's Evaluation and Recommendation (Complete for ICF/ID only)

48. Does medical regimen of the individual need to be under the supervision of an M.D./D.O.?..... ☐ **Yes** ☐ **No**

49. Will the health status of the individual prevent participation in the active treatment of the ICF/ID program?..... ☐ **Yes** ☐ **No**

50. To your knowledge, does the individual have a condition of intellectual disability and/or a related condition?..... ☐ **Yes** ☐ **No**

51. Do you certify that this individual requires ICF/ID or ICF/ID-RC care?..... ☐ **Yes** ☐ **No**

52. Signature - I attest to Item 19 and Items 48 through 51 only. _____

53. Print Full Name _____

54. Date Completed (MM-DD-YY)	55. Physician's License No.

72. I attest that I have been delegated Items 19 and 48-51 by the physician whose license is noted in Item 55 and I am an APN/PA with the following valid license no.

Deaf Blind with Multiple Disabilities (DBMD)
Addendum to Intellectual Disability/Related Condition (ID/RC)

Part A: This applies **only** to DBMD participants/applicants and is only required for purpose code "2" ID/RC assessments.
I attest **only** to item numbers 19, 20, 22, 23, 24, 26 and 27, and I certify that this individual:

1. has a central visual acuity of 20/200 or less in the better eye with corrective lenses, or a field defect such that the peripheral diameter of visual field sub-tends an angular distance no greater than 20 degrees, or a progressive visual loss having a prognosis leading to one or both of these conditions;
2. has a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification, or a progressive hearing loss having a prognosis leading to this condition (an exception to this definition may be made for an individual with significant auditory and visual impairment with a poor prognosis, or for an individual whose ability to use hearing and/or vision is so limited, as a result of protracted inadequate use of either or both of these senses, that the individual functions as a deaf-blind person); and
3. in addition to deafness and blindness, the individual has one or more other disabling conditions that result in impairment to independent functioning. The combination of impairments must result in the same level-of-care criteria established by the state of Texas to certify individuals eligible for ICF/ID LOC VIII services under the Title XIX State Plan; and
4. is medically appropriate to participate in a community-based waiver program.

Signature – M.D./D.O.	Date	License No.

Printed Name - M.D./D.O.	State Licensed	M.D./D.O. Area Code and Telephone No.

Part B: This applies **only** to DBMD participants/applicants and is only required for purpose code "2" ID/RC assessments.
Personal social and medical information verifies that the individual named above:

1. has the presence of deaf-blindness, or a condition that will result in deaf-blindness and an additional disability that constitutes or results in a substantial impediment to his ability to function independently in the family and community, resulting in certification of eligibility for ICF/ID LOC VIII services; and
2. has a reasonable expectation that services will benefit him by improving his ability to function independently in the family and community.

I certify that the above statements are based on information kept in the individual's permanent record.

Signature – DBMD Case Manager	Date	Name – DBMD Provider Agency

Individual's Name	Medicaid No.

Community Living Assistance and Support Services (CLASS)
Addendum to Intellectual Disability/Related Condition (ID/RC)

This applies **only** to **CLASS** participants/applicants and is only required for purpose code "2" ID/RC assessments.
I attest **only** to item numbers 19, 20, 22, 23, 24, 26 and 27, and I certify that this individual is medically appropriate to participate in a community-based waiver program.

Signature – M.D./D.O.	Date	License No.
Printed Name - M.D./D.O.	State Licensed	M.D./D.O. Area Code and Telephone No.

Provider Certification

On behalf of this agency, I certify that to the best of my knowledge all information on this form is true and I also certify that the information represents those items of the individual's treatment plan as currently documented in the record. I further certify that this agency can provide the needed physical and medical care.

56. Signature - RN/LVN/QIDP/QDDP/Case Manager/Local Authority (LA) Service Coordinator/HCS Provider Representative

57. Print Full Name of RN/LVN/QIDP/QDDP/Case Manager/LA Service Coordinator/HCS Provider Representative	Title

58. Date (MM-DD-YYYY)

Requested Begin/End Dates

59. Begin Date (MM-DD-YYYY)	60. End Date (MM-DD-YYYY)

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61. LOC	62. LON
63. Effective Date (MM-DD-YYYY)	64. Expiration Date (MM-DD-YYYY)
65. Name of Reviewer	66. Date Reviewed (MM-DD-YYYY)

67. Name of Physician (if applicable)

Provider Comments

Reviewer Comments