Department of Mental Health, Mental Retardation and Substance Abuse Services

ENROLLMENT REQUEST

☐ Check if placing on Statewide Waiting List

Check type of Waiver: ☐ **MR WAIVER** ☐ **DAY SUPPORT WAIVER**

Coordinating CSB: _____ Provider #: _____

Social Security Number: _____ Date Service First Needed: **(Waitlist Only)** _____

Individual's Name: _____ (**FIRST**) _____ (**M.I.**) _____ (**LAST**) Birthdate: (mo/dy/year) _____

Race (for data purposes): **Medicaid Number**: **Male :** **Female**:

- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Native American
- ☐ Other (specify):

ICF/MR Level of Functioning Date Completed: _____

- ☐ Health Status
- ☐ Communication
- ☐ Task Learning Skills
- ☐ Personal/Self Care
- ☐ Mobility
- ☐ Behavior
- ☐ Community Living

Current Living Situation:

- ☐ Living in the community, at risk of institutionalization
- ☐ Resident of state Training Center
- ☐ Resident of state MH Hospital
- ☐ Applicant to state or community ICF/MR
- ☐ Resident of community ICF/MR
- ☐ Resident of Nursing Facility

Diagnostic Eligibility:

Name of evaluator: _____

License/Credentials/Title: _____

☐ _____ Date psychological evaluation completed

☐ Confirms diagnosis of mental retardation, as defined by AAMR; documentation in record addresses:

- ☐ Intellectual functioning
- ☐ Adaptive functioning
- ☐ Age of onset

☐ _____ Date standardized developmental evaluation completed, under 6 yrs. of age **for MR Waiver**

☐ Confirms "developmental risk" [**NOT APPLICABLE FOR DAY SUPPORT WAIVER**]

Comments:

_____

_____

_____

The individual or parent/legal guardian has been given the choice between institutional care and MR Community/Day Support Waiver services, has signed the "Documentation of Recipient Choice" form, and has selected MR or DS Waiver. With the submission of this form, I certify that the above information is accurate, complete and maintained in the individual's record.

_____ Date_____ Phone_____

Signature of CSB Representative/Case Manager

_____ Date_____ PROJECTED Start Date_____

Signature of MR Director

This form must be submitted with the Recipient Choice Form *(unless already submitted for Waiting List***).**

This individual has been screened and approved to receive MR/DS Waiver services and is waiting to receive MR/DS Waiver Medicaid eligibility determination.

_____ Date_____ Approved Start Date_____

Signature of OMR Representative

Instructions for the Completion of the Enrollment Request Form (DMAS-437)

If these are handwritten, please print clearly.

1. *Check if placing on Statewide Waiting List.*

2. *If enrolling, check type of Waiver.*

3. *Identifying Information*

- ***Coordinating CSB*:** Enter the name of the CSB providing (or contracting for) Case Management Services.

- ***Provider Number***: Enter the provider number of the CSB named in the previous block.

- ***Social Security Number***: Enter the individual's **9-digit** number.

- ***Date Service First Needed:*** This is only required for placement on the Statewide Waiting List. Enter the date the individual needs the services. To be eligible for placement on the Statewide Waiting List, individuals must actually be in need of Waiver services immediately or no longer than 30 days from the date of this request. Individuals who do not require services within the next 30 days, should have their names placed on the CSB Planning List, until such time as services are needed within 30 days. Once an individual is placed on the Statewide Waiting List, the Date Service First Needed will never change.

- ***Individual's Name***: Enter the individual's first name, middle initial and last name in the appropriate blocks.

- ***Birthdate***: Enter the individual's date of birth in the order "month-day-year."

- ***Race*** (used for data purposes only): Check the appropriate box that most accurately describes the individual's race.

- ***Medicaid Number***: Enter the individual's **12-digit** number.

- ***Male/Female***: Check the applicable box to indicate the individual's gender.

4. *ICF/MR Level of Functioning*

    - Enter the most recent date of completion of the LOF. It must be completed no earlier than 6 months prior to the start of MR Waiver services.

    - Check the LOF categories met by the individual. The individual must meet at least 2 in order to qualify for MR Waiver services.

5. *Current Living Situation*

Check the appropriate box that describes the individual's living arrangement at the time of this request (i.e., prior to MR Waiver services).

6. Diagnostic Eligibility

- ***Name of evaluator***: Enter the name of the individual who tested and summarized the individual's psychological or developmental evaluation.

- ***License/Credentials/Title***: Enter the evaluator's license, credentials or title as it appears on the psychological or developmental evaluation.

- ***Date of psychological evaluation***: If the individual is 6 years of age or older or under 6 and desiring Day Support Waiver, enter the date of the most recent psychological.

- ***Confirms diagnosis of mental retardation***: Check that this most recent psychological confirms a diagnosis of mental retardation. Check also that this psychological addresses the three required components. Adaptive functioning and age of onset may also be checked if these are addressed in other documents contained in the individual's record, but should be easily accessible for review in the record. All of these 3 elements must be checked for approval.

- ***Date . . . developmental evaluation completed***: If the individual is under 6 years of age and desiring the MR Waiver, enter the date of the most recent developmental evaluation confirming developmental risk.

- ***Confirms developmental risk*** (if the individual is under the age of 6 and desiring the MR Waiver): Check that the most recent developmental evaluation confirms a diagnosis of developmental risk (as defined in Chapter VI). Children under 6 without an MR diagnosis are not eligible for the DS Waiver.

7. ***Comments***

Space is provided for any necessary explanations or other comments that will assist DMHMRSAS in determining eligibility for enrollment into the MR Waiver.

8. PROJECTED Start Date:

Enter the date it is anticipated that services will begin.

9. Signatures

The case manager or other responsible CSB representative must assure that the requirements listed are met by signing and dating the form, including the phone number of the signer as well.

The CSB MR Director (or a designee) must indicate agreement with this request, sign and date and include the requested start date for services to begin.