

Individual's Name: \_\_\_\_\_ ID#: \_\_\_\_\_

**INTERMEDIATE CARE FACILITY  
LEVEL OF FUNCTIONING SURVEY  
SUMMARY SHEET**

**NOTE:** *The individual must meet the indicated dependency level in 2 or more of the following categories to justify need for services in a Medicaid-certified facility for persons with mental retardation (intellectual disabilities) Intermediate Care Facility for the Mentally Retarded (ICF/MR).*

Date:		Date:		Date:		
MET	NOT MET	MET	NOT MET	MET	NOT MET	See qualifying option in each category below:
<input type="checkbox"/>	Category 1: Health Status Two or more questions answered with a 4 or Question "j" answered yes.					
<input type="checkbox"/>	Category 2: Communication Three or more questions answered with a 3 or 4.					
<input type="checkbox"/>	Category 3: Task Learning Skills Three or more questions answered with a 3 or 4					
<input type="checkbox"/>	Category 4: Personal/Self Care Question "a" answered with a 4 or 5 or Question "b" answered with a 4 or 5 or Question "c" and "d" answered with a 4 or 5					
<input type="checkbox"/>	Category 5: Mobility Any one question answered with a 4 or 5					
<input type="checkbox"/>	Category 6: Behavior Any one question answered with a 3 or 4					
<input type="checkbox"/>	Category 7: Community Living Skills Any two of questions "b", "e" or "g" answered with a 4 or 5 or Three or more questions answered with a 4 or 5					

Date: \_\_\_\_\_ Evaluator's Signature: \_\_\_\_\_  
Title/Affiliation: \_\_\_\_\_

Date: \_\_\_\_\_ Evaluator's Signature: \_\_\_\_\_  
Title/Affiliation: \_\_\_\_\_

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**LEVEL OF FUNCTIONING SURVEY**

**HEALTH STATUS**

1. How often is nursing care or nursing supervision by a licensed nurse required for the following...?  
(See instructions as it may also be provided by caregivers.)

*Please put appropriate number in the box under year of assessment.*

(Key: **1** = Rarely, **2** = Sometimes, **3** = Often, and **4** = Regularly)

		Date	Date	Date
a)	Medication administration and/or evaluation for effectiveness of a medication regimen			
b)	Direct services: i.e., care for lesions, dressings, treatments, (other than shampoos, foot powder, etc.)			
c)	Seizure Control			
d)	Teaching diagnosed disease control and care, including diabetes			
e)	Management of care of diagnosed circulatory or respiratory problems			
f)	Motor disabilities which interfere with all activities of Daily Living – Bathing, Dressing, Mobility, Toileting, Etc.			
g)	Observation for choking/aspiration while eating, drinking			
h)	Supervision of use of adaptive equipment, i.e., special spoon, braces, etc.			
i)	Observation for nutritional problems (i.e., undernourishment, swallowing difficulties, obesity)			
j)	Is age 55 or older, has a diagnosis of a chronic disease and has been in an institution 20 years or more.			

**Notes/Comments:**

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**2. COMMUNICATION**

How often does this person...?

*Please put appropriate number in the box under the year assessment.*

*(Key: 1 = regularly, 2 = often, 3 = sometimes, 4 = rarely)*

<input type="checkbox"/>	Verbal	Date	Date	Date
<input type="checkbox"/>	Non-verbal			
a)	Indicate wants by pointing, vocal noises, or signs?			
b)	Use simple words, phrases, and short sentences?			
c)	Ask for at least 10 things using appropriate names?			
d)	Understand simple words, phrases or instructions containing prepositions: i.e., "on", "in", "behind" ?			
e)	Speak in an easily understood manner?			
f)	Identify self, place or residence, and significant others?			

**Notes/Comments:**

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**3. TASK LEARNING SKILLS**

How often does this person perform the following activities...?

*Please put appropriate number in the box under the year assessment.*

*(Key: 1 = regularly, 2 = often, 3 = sometimes, 4 = rarely)*

		Date	Date	Date
a)	Pay attention to purposeful activities for 5 minutes?			
b)	Stay with a 3-step task for more than 15 minutes?			
c)	Tell time to the hour and understand time intervals?			
d)	Count more than 10 objects?			
e)	Do simple addition?			
f)	Write or print 10 words?			
g)	Discriminate shapes, sizes or colors?			
h)	Name people or objects when describing pictures?			
i)	Discriminate between "one", "many", "lot"?			

**Notes/Comments:**

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**4. PERSONAL/SELF-CARE**

With what type of assistance can this person currently...?

*Please put appropriate number in the box under the year assessment.*

*(Key: 1 = No Assistance, 2 = Prompting/Structuring, 3 = Supervision, 4 = Some Direct Assistance, 5 = Total Care)*

		Date	Date	Date
a)	Perform toileting functions i.e., maintain bladder and bowel continence, clean self, etc.?			
b)	Perform eating/feeding functions: i.e., drink liquids and eat with spoon or fork, etc?			
c)	Perform bathing function: i.e., bathe, run bath, dry self, etc.?			
d)	Dress self completely, i.e., including fastening and putting on clothes?			

**Notes/Comments:**

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**5. MOBILITY**

With what type of assistance can this person currently...?

*Please put appropriate number in the box under the year assessment.*

*(Key: 1 = No Assistance, 2 = Prompting/Structuring, 3 = Supervision, 4 = Some Direct Assistance, 5 = Total Care)*

		Date	Date	Date
<input type="checkbox"/>	Ambulatory			
<input type="checkbox"/>	Non-Ambulatory			
a)	Move (walking, wheeling) around environment?			
b)	Rise from lying down to sitting positions, sit without support?			
c)	Turn and position in bed, roll over?			

**Notes/Comments:**

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**6. BEHAVIOR**

How often does this person...?

*Please put appropriate number in the box under the year assessment.*

*(Key: 1 = Rarely, 2 = Sometimes, 3 = Often, 4 = Regularly)*

		Date	Date	Date
a)	Engage in self-destructive behavior?			
b)	Threaten or do physical violence to others?			
c)	Throw things or damage property, have temper outbursts?			
d)	Respond to others in a socially unacceptable manner – (without undue anger, frustration or hostility)?			

**Notes/Comments:**

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**7. COMMUNITY LIVING SKILLS**

With what type of assistance would this person currently be able to...?

*Please put appropriate number in the box under the year assessment.*

*(Key: 1 = No Assistance, 2 = Prompting/Structuring, 3 = Supervision, 4 = Some Direct Assistance, 5 = Total Care)*

		Date:	Date:	Date:
a)	Prepare simple foods requiring no mixing or cooking?			
b)	Take care of personal belongings, room (excluding vacuuming, ironing, clothes washing/drying, wet mopping)?			
c)	Add coins of various denominations up to one dollar?			
d)	Use telephone to call home, doctor, fire, police?			
e)	Recognize survival signs/words: i.e., stop, go, traffic lights, police, men, women, restrooms, danger, etc?			
f)	Refrain from exhibiting unacceptable sexual behavior in public?			
g)	Go around cottage, ward, building, without running away, wandering off, or becoming lost?			
h)	Make minor purchases, i.e., candy, soft drinks, etc.?			

**Notes/Comments:**