**Developmental Services Home and Community Based (HCB) Waiver Assessment (BMS-99)**

To determine initial medical eligibility for Comprehensive (Section 21) or Support (Section 29)

Waiver services, the below functional assessment must be completed by the Case Manager. Every twelve (12) months from the date of initial eligibility approval, an updated assessment form must be completed and submitted to the Department.

**Initial Classification** /  **Reclassification**

|  |  |  |
| --- | --- | --- |
| **Member Legal Name:** Click here to enter text. | **Date of Birth:**Click here to enter text. | |
| **EIS #:** Click here to enter text. | **MaineCare #:**Click here to enter text. | |
| **Current Diagnosis:** Click here to enter text. | | |
| **Legal Representative(s) (If applicable):** Click here to enter text.  **Legal Representative Address:** Click here to enter text. | **Legal Representative Email Address:** Click here to enter text.  **Legal Representative Phone #:** Click here to enter text. | |
| **Date last consumer planning meeting recommends ICF/IID or Waiver level of Services:** | | Click or tap to enter a date. |

The Home and Community Based Benefit (HCB or Benefit) is offered in a community-based setting as an alternative for members who qualify to live in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID- Section 50). HCB gives members eligible for this Benefit the option to live in their own home or in another home in the community thus avoiding or delaying institutional services.

**Examples of Covered ICF-IID (Section 50) Services**

**The following are examples of ICF-IID group home facility services and conditions. Any combination of examples may equate the needs for ICF-IID group home facility services.**

**1. Independent in mobility or in the use of a wheelchair or other mobility device.**

**2. May need assistance in personal care such as oral hygiene, care of skin, personal grooming and bathing.**

**3. May exhibit or has exhibited deviation from acceptable behavior.**

**4. May require some personal supervision.**

**5. May require some protection from environmental hazards.**

**6. Is able to participate, under supervision, in diversional and motivational activities both in the facility and in the community.**

**7. Is able to participate in one or more developmental, vocational or community programs.**

**8. Medications ordered by the physician are of a routine nature that can be administered by qualified group home facility personnel.**

**9. May be aphasic.**

# Summary of observed behavior and social history which determined level of need of care, based on ICF/IID examples:



### 4000 Character Limit

### Choose the Letter that Best applies and Explain

### A= Independent, B= Needs Supervision, C= Needs Skills Training, D= Needs Physical Assistance, E= Total Care

1. **Activates of Daily Living**

|  |  |
| --- | --- |
| **Eating** | Choose |
| **Dressing** | Choose |
| **Toileting** | Choose |
| **Bathing** | Choose |
| **Grooming** | Choose |
| **Mobility** | Choose |



4000 Character Limit

1. **Safety**

|  |  |
| --- | --- |
| **Avoidance of physical danger** | Choose |
| **Avoidance of emotional jeopardy** | Choose |
| **Engagement in healthy relationships** | Choose |
| **Judgement regarding personal conduct** | Choose |



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1. **Household Activities**

|  |  |
| --- | --- |
| Cooking | Choose |
| **Laundry** | Choose |



4000 Character Limit

1. **Community Access**

|  |  |
| --- | --- |
| **Shopping** | Choose |
| **Transportation** | Choose |
| **Banking** | Choose |
| **Recreation** | Choose |



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1. **Maintains Relationships**

|  |  |
| --- | --- |
| **Family** | Choose |
| **Friends** | Choose |
| **Coworkers** | Choose |
| **Support Staff** | Choose |



4000 Character limit

1. **Health Maintenance**

|  |  |
| --- | --- |
| **Accessing Medical Care** | Choose |
| **Emergency First-Aid** | Choose |
| **Accessing Mental Health Care** | Choose |
| **Medication Administration** | Choose |

  
 4000 Character limit

1. **Communication**

|  |  |
| --- | --- |
| **Expressive Communications** | Choose |
| **Receptive Communications** | Choose |
| **Sign Language** | Choose |
| **Visual/Gestural** | Choose |

 4000 Character limit

|  |  |
| --- | --- |
| **Name of Person Completing Assessment and Title:** Click here to enter text. | **Date of Review:**Click or tap to enter a date. |