ELIGIBILITY DETERMINATION FOR INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
STATE OF NEVADA
AGING AND DISABILITY SERVICES DIVISION
DEVELOPMENTAL SERVICES

DESERET REGIONAL CENTER
5550 W. Flamingo Road, Suite B5
Las Vegas, NV 89103
Phone: (702) 486-7850
Fax: (702) 486-5855

RURAL REGIONAL CENTER
1665 Old Hot Springs Road, Suite 157
Carson City, NV 89706
Phone: (775) 687-5162
Fax: (775) 687-1001

SIERRA REGIONAL CENTER
605 South 21st Street
Sparks, NV 89431-5599
Phone: (775) 688-1930
Fax: (775) 688-1947

Name: Birth Date: Age:
Date Application Received: Medicaid Billing No:

I. INTELLECTUAL DISABILITY DETERMINATION (applicant 6 years of age or older)

A. Does the applicant have an Intellectual Disability?
   □ Yes (Level: mild moderate severe profound unspecified) Person is eligible, sign below
   □ No (Please continue)

II. RELATED CONDITIONS DETERMINATION (applicant 6 years of age or older)

A. Does the person have a related condition diagnosis such as Autism Spectrum Disorder, Cerebral Palsy, or Seizure Disorder? (Excluded conditions are solely the effects of a mental disorder/mental illness, severe behavior disorder, severe emotional disturbance, learning disability, or a physical condition that is not neurological)
   □ Yes - List the diagnosis and the source □ No – Stop here the person is not eligible

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B. Is this person’s condition closely related to intellectual disability (because it results in impairments of general intellectual functioning or adaptive behavior similar to persons with intellectual disability, and requires treatment or services similar to those required for these persons)?
   □ Yes □ No – Stop here the person is not eligible

C. Does this person have a severe, chronic developmental disability as a result of a related condition diagnosis?
   □ Yes □ No – Stop here the person is not eligible

D. Did the developmental disability originate before age 22?
   □ Yes □ No – Stop here the person is not eligible

E. Is the developmental disability likely to continue indefinitely?
   □ Yes □ No – Stop here the person is not eligible
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F. Do standardized assessment tools and evaluative information show that the condition results in substantial functional limitations in three or more areas of major life activity?

☐ Yes ☐ No – Stop here the person is not eligible

Check all applicable
☐ Self-Care ☐ Understanding and Use of Language ☐ Learning ☐ Mobility ☐ Self-Direction

☐ Capacity for Independent Living

G. Does this person qualify for developmental disability services under related conditions?

☐ Yes ☐ No

III. DEVELOPMENTAL DELAY (for children under 6 years of age)
If applicable, list child’s medical or other condition associated with a developmental delay?

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A. Do standardized assessment tools and evaluative information show that the child evidences substantial functional limitations in two or more areas of major life activity?

☐ Yes ☐ No – Stop here the person is not eligible

Check all applicable
☐ Self-Care ☐ Understanding and Use of Language ☐ Learning ☐ Mobility ☐ Self-Direction

B. Does this person qualify for developmental disability services under Developmental Delay?

☐ Yes ☐ No

Comments related to determination:

__________________________________________________________________________________

Signature of Reviewing Psychologist: __________ Date: __________

Signature of Intake Coordinator: __________ Date: __________

Signature of Agency Director or designee: __________ Date: __________

Fiscal Eligibility

Financial ☐ Greater than 300% ☐ 300% ☐ 200%

Medicaid ☐ Not Eligible/Denied ☐ Yes ☐ Pending

State Eligibility Review Committee reviewed this case on __________ and determined the applicant to be ☐ eligible ☐ ineligible for services.

SIGNATURE OF INTAKE COORDINATOR OR DESIGNEE