

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

DESERT REGIONAL CENTER
 5550 W. Flamingo Road, Suite B5
 Las Vegas, NV 89103
 Phone: (702) 486-7850
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 Phone: (775) 687-5162
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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

DIAGNOSIS	SOURCE	DATE

- 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?

DIAGNOSIS	SOURCE	DATE

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