Home Care Allowance Eligibility Determination	
Client Name:	SSN:

	Client Functional Capacity (Impairment) ----- I(0) L(1) M(2) S(3)	Documentation	Need For Paid Care (Frequency) ----- N(0) W(1) D(2) T(3)
Critical ADLs			
Transfers			
Bladder Care			
Bowel Care			
Basic ADLs			
Mobility			
Dressing			
Bathing			
Hygiene			
Eating			
Basic IADLs			
Meal			
Housework			
Laundry			
Shopping			
Supportive ADLs			
Medicine Management			
Appointment Management			
Money Management			
Access Resources			
Telephone			
	Functional Capacity Score		**Need For Paid Score**

Home Care Allowance Eligibility Determination

Client Name:	SSN:

Home Care Allowance Computation And Approval

HCA Payment Authorization	**HCA Paid By Client To**	**Program Approval**
Authorized Amount: _____ Total Client Income: _____ Grant Amount: _____ Payment Effective: _____	**HCA Hours Of Paid Care Needed Per Week** Hours:	**Program Denial** Denial Date: Letter Sent: no

Group: DD/MR

Case Manager Signature	Date	Supervisor Signature	Date
Case Manager Electronic Signature	Date	Supervisor Electronic Signature	Date