WEST VIRGINIA BUREAU OF SENIOR SERVICES
Lighthouse Eligibility Determination

Service recipient name: _____

Date of Birth: _____ Gender: ☐ Female ☐ Male Marital Status: _____

Mailing/Physical Address: _____

City: _____ Zip: _____

County of Residence: _____ Phone Number: _____

Monthly Income: _____

Assets Greater than $2000 ☐ Yes ☐ No

Informal Support's name: _____

Relationship: _____ Phone Number: _____

Medicaid Number (if applicable): _____

QMB: ☐ Yes ☐ No

Does applicant meet the financial guidelines for the Aged and Disabled Waiver or Personal Care Program? ☐ Yes ☐ No

Is applicant a potential Medicaid Personal Care or Aged and Disabled Waiver referral with 3-5 deficits in the key areas: eating, bathing, dressing, grooming, incontinence-bowel, incontinence-bladder, intermittent disorientation, decubitus stage 3 or 4, in an emergency, mentally or physically unable to vacate?

☐ Yes ☐ No ☐ N/A

Has an Aged and Disabled Waiver Referral been completed?

☐ Yes ☐ No

Additional Comments

Activities of Daily Living:

Determine need for each ADL. Must be level 2 or 3 in two or more areas to qualify. Do not use ranges. Use the level of assistance the person requires on most days.

0 – Independent
1 – Some Assistance
2 – Much Assistance
3 – Total Assistance

- ☐ Grooming
- ☐ Bathing
- ☐ Dressing
- ☐ Toileting
- ☐ Feeding
- ☐ Meal Prep
- ☐ Transferring
- ☐ Walking

Eligibility must be determined by Registered Nurse. Signature below signifies that determination.

Applicant **has not** been determined eligible for the Lighthouse Program.

RN Signature Date

Applicant **has** been determined eligible for the Lighthouse Program.

RN Signature Date