

TITLE: CERTIFICATION OF NEED FOR ICF/ID OR ICF/ORC LEVEL OF CARE

This application is from the Department of Human Services, Office of Developmental Programs. If you need language assistance, free of charge, please call 1-888-565-9435.

本申请来自发展计划办公室公共事业部。如果您需要语言帮助, 请拨打免费电话 1-888-565-9435。

Esta solicitud es de la Oficina de Programas de Desarrollo del Departamento de Servicios Humanos. Si necesita ayuda gratuita con el idioma, por favor llame al 1-888-565-9435.

ពាក្យសុំនេះមកពីក្រសួងសេវាកម្មពលរដ្ឋ នៃការិយាល័យកម្មវិធីអភិវឌ្ឍ។ ប្រសិនបើលោកអ្នកត្រូវការជំនួយភាសាដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទលេខ 1-888-565-9435 ។

Настоящее заявление направлено из Отдела программ для лиц с пороками развития Департамента социального обеспечения. Если вам требуется бесплатная помощь переводчика, обращайтесь по телефону 1-888-565-9435.

Đơn xin này từ Bộ Dịch Vụ Nhân Sinh, Văn Phòng Chương Trình Phát Triển. Nếu quý vị cần trợ giúp ngôn ngữ miễn phí, xin vui lòng gọi 1-888-565-9435.

FUNDING SOURCE: HCBS waiver ICF

I. PURPOSE. THE PURPOSE OF THIS FORM IS TO CERTIFY WHETHER THE FOLLOWING NAMED INDIVIDUAL REQUIRES AN ICF/ID OR ICF/ORC LEVEL OF CARE FOR DETERMINING ELIGIBILITY FOR HOME AND COMMUNITY SERVICES FUNDED UNDER THE CONSOLIDATED, PERSON/FAMILY DIRECTED SUPPORT WAIVER, COMMUNITY LIVING WAIVER, TARGETED SUPPORT MANAGEMENT FOR INDIVIDUALS WITH A DIAGNOSIS OF AUTISM, OR FOR ADMISSION TO AN ICF/ID OR ICF/ORC FACILITY.

INDIVIDUAL'S NAME:

CURRENT ADDRESS:

CITY: STATE: ZIP:

DATE OF BIRTH: (MM/DD/YYYY) MCI #: SOCIAL SECURITY NUMBER: TELEPHONE NUMBER: ()

II. QUALIFIED DEVELOPMENTAL DISABILITY PROFESSIONAL CERTIFICATION. (COMPLETE SECTION A IF THE INDIVIDUAL MEETS ICF/ID OR ICF/ORC LEVEL OF CARE CRITERIA OR SECTION B IF THE INDIVIDUAL DOES NOT. PLEASE CIRCLE EITHER ICF/ID OR ICF/ORC WHEN COMPLETING A. 1. OR WHEN COMPLETING B.)

- A. I HEREBY CERTIFY THAT THIS INDIVIDUAL:
1. HAS COMPLETED ALL STANDARDIZED ASSESSMENTS AND PSYCHOLOGICAL, SOCIAL, AND MEDICAL EVALUATIONS NECESSARY TO DETERMINE NEED FOR AN ICF/ID OR ICF/ORC LEVEL OF CARE IN ACCORDANCE WITH CRITERIA ESTABLISHED BY THE DEPARTMENT OF HUMAN SERVICES, OFFICE OF DEVELOPMENTAL PROGRAMS.

and

 2. WILL BENEFIT FROM CONSISTENT IMPLEMENTATION OF A PROGRAM OF SPECIALIZED AND GENERIC TRAINING, TREATMENT AND HEALTH OR RELATED SERVICES, DIRECTED TOWARD HELPING THE PERSON FUNCTION WITH AS MUCH SELF-DETERMINATION AND INDEPENDENCE AS POSSIBLE.

_____ QDDP SIGNATURE _____ DATE
 _____ ADDRESS _____ TELEPHONE NUMBER

B. I HEREBY CERTIFY THAT THIS INDIVIDUAL DOES NOT REQUIRE AN ICF/ID OR ICF/ORC LEVEL OF CARE BASED ON THE CRITERIA ESTABLISHED BY THE DEPARTMENT OF HUMAN SERVICES, OFFICE OF DEVELOPMENTAL PROGRAMS.

_____ QDDP SIGNATURE _____ DATE
 _____ ADDRESS _____ TELEPHONE NUMBER

III. DETERMINATION BY THE DEPARTMENT OF HUMAN SERVICES DESIGNEE, THE COUNTY MH/ID PROGRAM OR ADMINISTRATIVE ENTITY.

THIS INDIVIDUAL IS DETERMINED TO REQUIRE AN ICF/ID OR ICF/ORC LEVEL OF CARE. (CIRCLE EITHER ICF/ID OR ICF/ORC)

_____ COUNTY MH/ID PROGRAM OR ADMINISTRATIVE ENTITY SIGNATURE _____ DATE

THIS INDIVIDUAL IS DETERMINED TO NOT REQUIRE AN ICF/ID OR ICF/ORC LEVEL OF CARE. (CIRCLE EITHER ICF/ID OR ICF/ORC)

_____ COUNTY MH/ID PROGRAM OR ADMINISTRATIVE ENTITY SIGNATURE _____ DATE

_____ ADDRESS _____ TELEPHONE NUMBER