

# 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.)

- 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.

COUNTY MH/ID PROGRAM OR ADMINISTRATIVE ENTITY SIGNATURE	DATE
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THIS INDIVIDUAL IS DETERMINED TO NOT REQUIRE AN ICF/ID OR ICF/ORC LEVEL OF CARE.

COUNTY MH/ID PROGRAM OR ADMINISTRATIVE ENTITY SIGNATURE	DATE
ADDRESS	(    ) TELEPHONE NUMBER