

# TITLE: ANNUAL RECERTIFICATION 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 INDIVIDUAL WHO IS RECEIVING HOME AND COMMUNITY SERVICES FUNDED UNDER THE CONSOLIDATED WAIVER, PERSON/FAMILY DIRECTED SUPPORT WAIVER, COMMUNITY LIVING WAIVER, TARGETED SUPPORT MANAGEMENT FOR INDIVIDUALS WITH A DIAGNOSIS OF AUTISM, OR RECEIVING SERVICES IN AN ICF/ID OR ICF/ORC IS DETERMINED TO CONTINUE TO QUALIFY FOR AN ICF/ID OR ICF/ORC LEVEL OF CARE IN ACCORDANCE WITH STATE AND FEDERAL REQUIREMENTS.

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**

THE ANNUAL RE-EVALUATION OF NEED FOR AN ICF/ID OR ICF/ORC LEVEL OF CARE IS MADE BY THE FOLLOWING NAMED QUALIFIED DEVELOPMENTAL DISABILITY PROFESSIONAL BASED ON THE COMPLETION OF THE WAIVER RE-EVALUATION TOOL UTILIZING STANDARD SIS SCORES, AS WELL AS A REVIEW OF THE BENEFIT THE INDIVIDUAL IS RECEIVING FROM HOME AND COMMUNITY SERVICES AND SUPPORTS OR CONTINUED STAY IN AN ICF/ID OR ICF/ORC. SECTION A IS COMPLETED IF THE INDIVIDUAL CONTINUES TO QUALIFY FOR AN ICF/ID OR ICF/ORC LEVEL OF CARE OR SECTION B IS COMPLETED IF THE INDIVIDUAL DOES NOT MEET THE CRITERIA.

A. I CERTIFY AS A QUALIFIED DEVELOPMENTAL DISABILITY PROFESSIONAL THAT THE ABOVE NAMED INDIVIDUAL CONTINUES TO QUALIFY FOR AN ICF/ID OR ICF/ORC LEVEL OF CARE. (circle one)

\_\_\_\_\_ QDDP SIGNATURE

\_\_\_\_\_ DATE

\_\_\_\_\_ ADDRESS

( )

\_\_\_\_\_ TELEPHONE NUMBER

B. I CERTIFY AS A QUALIFIED INTELLECTUAL DISABILITY PROFESSIONAL THAT THE ABOVE NAMED INDIVIDUAL DOES NOT CONTINUE TO QUALIFY FOR AN ICF/ID OR ICF/ORC LEVEL OF CARE.

\_\_\_\_\_ QDDP SIGNATURE

\_\_\_\_\_ DATE

\_\_\_\_\_ ADDRESS

( )

\_\_\_\_\_ TELEPHONE NUMBER

**III. LEVEL OF CARE DETERMINATION**

THIS SECTION IS SIGNED BY THE DEPARTMENT DESIGNEE, THE COUNTY MH/ID PROGRAM OR ADMINISTRATIVE ENTITY. SECTION A IS SIGNED IF THE INDIVIDUAL IS DETERMINED TO CONTINUE TO REQUIRE AN ICF/ID OR ICF/ORC LEVEL OF CARE. SECTION B IS SIGNED IF THE INDIVIDUAL IS DETERMINED TO NOT QUALIFY FOR AN ICF/ID OR ICF/ORC LEVEL OF CARE.

A. THE DEPARTMENT OF HUMAN SERVICES DESIGNEE, THE COUNTY MH/ID PROGRAM OR ADMINISTRATIVE ENTITY, HEREBY DECREES THAT THIS INDIVIDUAL CONTINUES TO QUALIFY FOR AN ICF/ID OR ICF/ORC LEVEL OF CARE.

\_\_\_\_\_ COUNTY MH/ID PROGRAM OR ADMINISTRATIVE ENTITY SIGNATURE

\_\_\_\_\_ DATE

B. THE DEPARTMENT OF HUMAN SERVICES DESIGNEE, THE COUNTY MH/ID PROGRAM OR ADMINISTRATIVE ENTITY, HEREBY DECREES THAT THIS INDIVIDUAL DOES NOT CONTINUE TO REQUIRE AN ICF/ID OR ICF/ORC LEVEL OF CARE.

\_\_\_\_\_ COUNTY MH/ID PROGRAM OR ADMINISTRATIVE ENTITY SIGNATURE

\_\_\_\_\_ DATE