## Level of Care Evaluation /Eligible for ICF/ID or ICF/ORC – Results of review

DATE

Individual’s or Surrogate’s Name

Address

Address

Dear [Name of Individual or Surrogate]:

This letter is to inform you that the \_\_\_\_\_\_\_AE conducted a Level of Care evaluation to determine \_\_\_\_\_\_\_\_\_\_\_\_\_ (participant’s name) eligibility for participation in the Home and Community Based Waiver Program. This letter confirms that you have met the ICF/ID or ICF/ORC Level of Care requirements for ODP Waivers. A completed DP 250 titled *Certification of need for ICF/ID or ICF/ORC Level of Care* is enclosed with this correspondence.

For your future reference, it is a requirement that a Level of Care evaluation be completed annually. The annual re-evaluation of need for an ICF/ID or ICF/ORC Level of Care is based on the completion of the waiver re-evaluation tool utilizing standard Supports Intensity Scale (SIS) scores, as well as a review of the benefit (participant’s name) is receiving from home and community-based services and supports. Our office will conduct this re-evaluation and notify you of our determination. You may be asked to provide an updated medical evaluation at that time.

 Additionally, the County Assistance Office may request at any time financial information necessary to determine your ongoing eligibility for Medical Assistance. Failure to respond timely to these requests will result in a “not eligible” determination and termination from either the Waiver program and/or Medical Assistance. All termination notices will be sent from the County Assistance Office via a PA 162 Form.

Sincerely,

Enclosure

DP 250

cc: Supports Coordinator