## Level of Care Re-evaluation/Not Eligible – 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 an annual Level of Care re-evaluation to determine \_\_\_\_\_\_\_\_\_\_\_\_\_(participant’s name) eligibility for continued participation in the Office of Developmental Program’s Home and Community Based Waiver Program. This letter provides you notice that you **did not** meet the ICF/ID or ICF/ORC Level of Care requirements. The reason you failed to meet the requirement is indicated as follows:

*Please check*

* Failure to submit requested document/s – Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Failure to meet Level of Care – Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Failure to need ICF/ID or ICF/ORC Level of Care per physician’s recommendation
* Failure to meet re-evaluation criteria through the use of the waiver re-evaluation tool based on SIS standard scores

A completed DP 251 titled *Annual Re-evaluation of Need for the ICF/ID or ICF/ORC,* andthe results of the waiver tool based on the Supports Intensity Scale (SIS) scores are enclosed with this correspondence. Your ICF/ID or ICF/ORC Level of Care determination was communicated to your local County Assistance Office. You will receive a waiver eligibility notice from them.

Under State and Federal rules, you have certain fair hearing rights afforded to you at this time. These rights and a copy of the Fair Hearing and Appeal Instructions and Request Form (DP 458) are enclosed. The appeal must be postmarked by \_\_\_\_\_\_\_\_\_\_\_\_\_ (Date 30 calendar days in the future) to be heard by the Department of Human Services, Bureau of Hearings and Appeals.

If you have any questions, please contact me at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Sincerely,

Enclosure

DP251

DP 458

cc: Supports Coordinator