Waiver ICF/ID LOC documentation – Initial (waiver capacity available)

DATE

Individual’s or Surrogate’s Name

Address

Address

Dear [Name of Individual or Surrogate]:

You are receiving this letter because you expressed an interest in receiving Waiver services through the Office of Developmental Programs. Previously, you were determined “likely to meet” ICF/ID Level of Care and indicated under Service Preference – Home and Community Based Services under the Waiver. This letter is to inform you that waiver capacity has been identified for you and it is our intent to proceed with the enrollment process for the \_\_\_\_\_\_\_\_\_\_ Waiver, unless your interest in the program has changed.

The Level of Care criteria must be validated before Waiver enrollment is finalized. The ICF/ID level of care determination must be completed by \_\_\_[a date 45 calendar days in the future\_\_ to comply with Waiver requirements.

The following documentation is required as part of the formal Level of Care evaluation process. Please send this office only the items that are checked below:

□ The results of a medical evaluation completed within the previous 365 calendar days that reflects the individual’s current medical condition. A medical form is enclosed for your use. A recommendation for ICF/ID Level of Care must be made by the practitioner.

□ The results of a standardized intelligence test conducted by a licensed psychologist, certified school psychologist, psychiatrist, developmental pediatrician, or licensed physician who practices psychiatry that shows significantly sub-average intellectual functioning.

□ The results of an adaptive behavior skills standardized assessment (for example, the Vineland Adaptive Behavior Scales) that shows the individual has substantial functional limitation in three or more of the following areas of major life activity:

* Self-care
* Receptive and expressive language
* Learning
* Mobility
* Self-direction
* Capacity for independent living

□ Documentation that substantiates that these conditions of intellectual and adaptive functioning manifested before the individual reached 22 years of age.

□ Documentation that a diagnosis of Intellectual Disability was made or confirmed by a licensed clinician.

Upon receipt of all requested documentation the formal determination process will begin. You may be contacted during the course of this review should questions arise.

The determination of ICF/ID level of care will be documented on DP 250, *“Certification of Need for ICF/ID or ICF/ORC Level of Care”* and sent to you upon completion*.* In addition, the determination of ICF/ID level of care will be shared with your local County Assistance Office as part of the Medicaid eligibility process for (INSERT PROGRAM NAME) Waiver enrollment.

If you have any questions regarding this letter, please contact me at \_\_(Telephone Number)\_\_\_.

Sincerely,

Name

Waiver Coordinator

County MH/ID Program or Administrative Entity

cc: Individual’s File

Individual’s Surrogate [if applicable]

Supports Coordinator