Waiver ICF/ID LOC documentation – Initial (no waiver capacity)

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. You were determined to meet intermediate care facility for individuals with intellectual disability (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 is not available at this time. It is our intent to proceed with enrollment when capacity becomes available.

While capacity is not available at this time, you are eligible to receive Supports Coordination services through Targeted Services Management (TSM). The Administrative Entity (AE) will provide you with additional information and your choice of a Supports Coordination Organization (SCO).

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