Waiver ICF/ORC LOC for people with ASD documentation – Additional Information Required

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. Upon review it has been determined that additional information is required in order to determine if you meet the criteria for ICF/ORC level of care for people with ASD.

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 with this letter. A recommendation for ICF/ORC Level of Care must be made by the practitioner.

□ The results of standardized assessment of adaptive functioning (for example, the Adaptive Behavior Assessment System) 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 adaptive functioning manifested before the individual reached 22 years of age.

□ Documentation that a diagnosis of Autism Spectrum Disorder as documented in a diagnostic tool(s) was made or confirmed by a licensed psychologist, certified school psychologist, psychiatrist or a licensed physician who practices psychiatry.

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/ORC level of care for people with ASD 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/ORC level of care for people with ASD 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

Administrative Entity

cc: Individual’s File

Individual’s Surrogate [if applicable]

Supports Coordinator