

Date

(Individual's Name or Surrogate's Name)
(Address)
Address)

Dear :

This letter is to advise that (Name of Individual) has been determined to be likely to meet ICF/MR level of care and other Medical Assistance eligibility requirements that would qualify (Name of Individual) to obtain placement in an Intermediate Care Facility for Mentally Retarded (ICF/MR). This is based on a preliminary determination of eligibility for ICF/MR level of care and will be subject to formal review before placement is made to an ICF/MR. Feasible alternatives to ICF/MR placement were reviewed with you so that an informed decision could be made regarding service delivery preference. A copy of your Home and Community-Based or ICF/MR Application and Service Delivery Preference Form (DP 457) is enclosed.

The County MH/MR Program or Administrative Entity (AE) will be completing the following activities to ensure that you receive the services you need as promptly as possible:

- A Prioritization of Urgency of Need for Services (PUNS) form will be completed to document your current unmet need for services or anticipated need for services in the future. If you already have had a PUNS completed, the PUNS will be updated if your needs change substantially. The PUNS will be used by the County Program or AE when placement becomes available in an ICF/MR and in planning for future need.
- If you would like a list of ICFs/MR, please contact the County Program or AE. Both you and the County Program or AE may contact any ICF/MR program for availability information.

When an available ICF/MR is found and before placement can be made to that facility, (Name of Individual) will need to obtain a physical examination to reflect (Name of Individual)'s current medical condition. In accordance with 55 Pa.Code § 6210.64, "applicants or recipients meeting the ICF/MR level of care shall have a medical examination completed by a physician not more than 60 days prior to the admission to an ICF/MR". You will be contacted by your Supports Coordinator when the results of the examination are needed to continue processing the ICF/MR placement.

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.

If you have any questions about this information, please contact your Supports Coordinator, (Name of Supports Coordinator) at (Phone Number). Your Supports Coordinator can answer questions about your PUNS and funding.

Thank you for your attention to this matter.

Sincerely,

(Name)

County MH/MR Program or Administrative Entity

Enclosures

DP 457, Home and Community-Based or ICF/MR Application and Service
Delivery Preference Form
DP 458, Fair Hearing Request Form

cc: MR Director
SC Entity Director
Supports Coordinator
File