

DATE

Individual's or Surrogate's Name

Address

Address

Dear [Name of Individual or Surrogate]:

An evaluation was recently conducted by a Qualified Mental Retardation Professional (QMRP) to determine whether           (Name of Individual)           requires a level of care normally provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). This evaluation is required as part of the process to enroll           (Name of Individual)           in the           (Name of Waiver)           Waiver. This letter is to notify you of the decision that was made by the QMRP who conducted the review.

As explained to you in the letter of           (Date of Letter)          , the QMRP reviewed available histories and information in order to certify that           (Name of Individual)           has a diagnosis of mental retardation, requires active treatment, and is recommended for an ICF/MR level of care.

The QMRP has determined that           (Name of Individual)           meets the ICF/MR level of care requirements necessary to be enrolled in the           (Name of Waiver)           Waiver. Enclosed is a completed and signed copy of form DP 250, "Certification of Need for ICF/MR level of Care", that certifies and documents that           (Name of Individual)           meets this requirement.

The ICF/MR level of care decision was communicated to your local County Assistance Office. You will receive a notice from that office as part of the Medicaid Waiver eligibility determination process.

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

Sincerely,

Name

Waiver Coordinator

County MH/MR Program or Administrative Entity

Enclosure

DP 250, "Certification of Need for ICF/MR level of Care"

cc: Individual's File

Individual's Surrogate (if applicable)

Individual's Supports Coordinator