

DATE

Individual's or Surrogate's Name
Address
Address

Dear [Name of Individual or Surrogate]:

A re-determination of the Waiver requirement to need a level of care normally provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) was recently conducted for (Name of Individual) . This letter is to notify you of the decision that was made by the Qualified Mental Retardation Professional (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 recertify that (Name of Individual) has a diagnosis of mental retardation, continues to require active treatment, and continues to be 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 continue enrollment in the [Name of Waiver] Waiver. Enclosed is a completed and signed copy of form DP 251, "*Annual Recertification of Need for ICF/MR Level of Care*", that recertifies and documents that (Name of Individual) meets this requirement.

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

Sincerely,

Name
Waiver Coordinator
County MH/MR Program or Administrative Entity

Enclosure

DP 251, "*Re-Certification of Need for ICF/MR level of Care*"

cc: Individual's File
Individual's Surrogate [if applicable]
Individual's Supports Coordinator
Residential Provider [if applicable]