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)__ does not meet the ICF/MR level of care requirements necessary to continue enrollment in the __[Name of Waiver]___ Waiver. The reasons for this decision are as follows:

_____(Insert Reasons Here)_____

Enclosed is a completed and signed copy of form DP 251, *"Re-Certification of Need for ICF/MR level of Care",* that certifies and documents that ___(Name of Individual)__ does not meet this requirement.

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

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. The appeal must be postmarked by _____[Date 30 calendar days in the future]___ to be heard by the Department of Public Welfare, Bureau of Hearings and Appeals.

All Waiver services will stop effective with the Medicaid discontinuance date issued in conjunction with the County Assistance Office eligibility re-determination process. You are afforded appeal rights through the Department of Public Welfare's Bureau of Hearings and Appeals. An appeal must be filed before the Medicaid discontinuance date for Waiver services to continue

uninterrupted. The appeal will be filed using the enclosed form DP 458, *"Fair Hearing Request Form"*. If you require assistance to file the appeal, please contact this office or your Supports Coordinator.

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 251, *"Re-Certification of Need for ICF/MR level of Care"*
DP 458, *"Fair Hearing Request Form"*

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