TITLE: ANNUAL RECERTIFICATION OF NEED FOR ICF/MR LEVEL OF CARE

This application is from the Department of Public Welfare, Office of Developmental Programs. If you need language assistance, free of charge, please call 1-888-565-9435.

Esta solicitud es del Departamento de Bienestar Público, Oficina de Programas de Desarrollo. Si necesita ayuda con el idioma, gratis, llame por favor al 1-888-565-9435.

ពាក្យដាក់សុំនេះចេញពីក្រសួងសាធារណៈជំនួយថ្លៃ ការិយាល័យទទួលបន្ទុកលើកម្មវិធីបណ្តុះបណ្តាល។ បើលោកអ្នកត្រូវការជំនួយផ្នែកភាសា ដោយមិនបាច់ចេញលុយ សូមទូរស័ព្ទមក 1-888-565-9435។

这是公共福利部发展计划办公室提供的申请书．你如果需要语言方面的免费协助，请致电 1-888-565-9435.

Настоящее заявление – от Бюро программ развития Отдела социального обеспечения (Department of Public Welfare). Если вам нужна помощь переводчика, звоните по телефону 1-888-565-9435 (бесплатно).

Mẫu đơn này là của Sở Trợ Cấp Phúc Lợi Công Cộng, Văn Phòng Phát Triển các Chương Trình. Nếu quý vị muốn được trợ giúp về ngôn ngữ, miễn phí, xin gọi số 1-888-565-9435.

FUNDING SOURCE: ☐ P/FDS WAIVER ☐ CONSOLIDATED WAIVER ☐ ICF/MR

I. PURPOSE. THE PURPOSE OF THIS FORM IS TO CERTIFY WHETHER THE FOLLOWING INDIVIDUAL WHO IS RECEIVING HOME AND COMMUNITY SERVICES FUNDED UNDER THE CONSOLIDATED OR PERSON/FAMILY DIRECTED SUPPORT WAIVERS OR IN AN ICF/MR IS DETERMINED TO CONTINUE TO QUALIFY FOR AN ICF/MR LEVEL OF CARE IN ACCORDANCE WITH STATE AND FEDERAL REQUIREMENTS.

INDIVIDUAL'S NAME:		
CURRENT ADDRESS:		
CITY:	STATE:	ZIP:
DATE OF BIRTH: (*MM/DD/YYYY*)	SOCIAL SECURITY NUMBER:	TELEPHONE NUMBER: ( )

II. QUALIFIED MENTAL RETARDATION PROFESSIONAL CERTIFICATION

THE ANNUAL RECERTIFICATION OF NEED FOR AN ICF/MR LEVEL OF CARE IS MADE BY THE FOLLOWING NAMED QUALIFIED MENTAL RETARDATION PROFESSIONAL BASED ON REVIEW OF THIS INDIVIDUAL'S PSYCHOLOGICAL, SOCIAL, AND PHYSICAL CONDITION, AS WELL AS A REVIEW OF THE BENEFIT THE INDIVIDUAL IS RECEIVING FROM HOME AND COMMUNITY SERVICES AND SUPPORTS OR CONTINUED STAY IN AN ICF/MR. SECTION A IS COMPLETED IF THE INDIVIDUAL CONTINUES TO QUALIFY FOR AN ICF/MR LEVEL OF CARE OR SECTION B IS COMPLETED IF THE INDIVIDUAL DOES NOT MEET THE CRITERIA.

A. I CERTIFY AS A QUALIFIED MENTAL RETARDATION PROFESSIONAL THAT THE ABOVE NAMED INDIVIDUAL CONTINUES TO QUALIFY FOR AN ICF/MR LEVEL OF CARE.

QMRP SIGNATURE _____ DATE _____

ADDRESS _____ ( ) TELEPHONE NUMBER _____

B. I CERTIFY AS A QUALIFIED MENTAL RETARDATION PROFESSIONAL THAT THE ABOVE NAMED INDIVIDUAL DOES NOT CONTINUE TO QUALIFY FOR AN ICF/MR LEVEL OF CARE.

QMRP SIGNATURE _____ DATE _____

ADDRESS _____ ( ) TELEPHONE NUMBER _____

III. LEVEL OF CARE DETERMINATION *

THIS SECTION IS SIGNED BY THE DEPARTMENT DESIGNEE, THE COUNTY MH/MR PROGRAM OR ADMINISTRATIVE ENTITY. SECTION A IS SIGNED IF THE INDIVIDUAL IS DETERMINED TO CONTINUE TO REQUIRE AN ICF/MR LEVEL OF CARE. SECTION B IS SIGNED IF THE INDIVIDUAL IS DETERMINED NOT TO QUALIFY FOR AN ICF/MR LEVEL OF CARE.

A. THE DEPARTMENT OF PUBLIC WELFARE DESIGNEE, THE COUNTY MH/MR PROGRAM OR ADMINISTRATIVE ENTITY, HEREBY DETERMINES THAT THIS INDIVIDUAL CONTINUES TO QUALIFY FOR AN ICF/MR LEVEL OF CARE.

COUNTY MH/MR PROGRAM OR ADMINISTRATIVE ENTITY SIGNATURE _____ DATE _____

B. THE DEPARTMENT OF PUBLIC WELFARE DESIGNEE, THE COUNTY MH/MR PROGRAM OR ADMINISTRATIVE ENTITY, HEREBY DETERMINES THAT THIS INDIVIDUAL DOES NOT CONTINUE TO REQUIRE AN ICF/MR LEVEL OF CARE.

COUNTY MH/MR PROGRAM OR ADMINISTRATIVE ENTITY SIGNATURE _____ DATE _____

**DO NOT COMPLETE THIS SECTION IF RECERTIFICATION IS FOR CONTINUED STAY IN AN ICF/MR.*