ICF/ID OR ICF/ORC LOC – Initial (no waiver capacity)

DATE

Individual’s or Surrogate’s Name

Address

Address

Dear [Name of Individual or Surrogate]:

You are receiving this letter because you expressed an interest in receiving services through the Office of Developmental Programs. You were determined to meet Intermediate Care Facility for Persons with an Intellectual Disability (ICF/ID) or Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC) Level of Care. A completed DP 250 titled Certification of Need for ICF/ID or ICF/ORC Level of Care is enclosed with this correspondence.

This letter is to inform you that waiver capacity is not available at this time. It is our intent to proceed with enrollment in a waiver when capacity becomes available.  However, you are eligible to receive Supports Coordination services through Targeted Supports Management (TSM). The Administrative Entity (AE) will provide you with additional information and your choice of a willing and qualified Supports Coordination Organization (SCO).

For your future reference, an ICF/ORC Level of Care evaluation must be completed annually.

Additionally, to remain eligible for Targeted Support Management, you must be eligible for Medical Assistance. You will receive a notice from the County Assistance Office via a PA 162 Form to confirm eligibility.

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

Sincerely,

Name

Waiver Coordinator

County MH/ID Program or Administrative Entity

Enclosure:

DP 250

cc: Individual’s File

Individual’s Surrogate [if applicable]

Supports Coordinator