ICF/ID or ICF/ORC LOC for Individuals– Initial (waiver capacity available)

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 ICF/ID or ICF/ORC Level of Care. You have indicated a service preference of Home and Community Based Services through the Waiver. This letter is to inform you that waiver capacity has been identified for you and it is our intent to proceed with the enrollment process for the \_\_\_\_\_\_\_\_\_\_ Waiver if you are still interested.

Please contact our office within 10 business days of receipt of this letter to finalize the enrollment process. The Level of Care criteria will be validated before Waiver enrollment is finalized.

The determination of ICF/ID or ICF/ORC level of care for individuals will be documented on DP 250, *“Certification of Need for ICF/ID or ICF/ORC Level of Care.”.* In addition, the determination of ICF/ID or ICF/ORC level of care will be shared with your local County Assistance Office as part of the Medicaid eligibility process for (INSERT PROGRAM NAME) Waiver enrollment.

Additionally, to remain eligible for Waiver services you must also continue to 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

Administrative Entity

Enclosure DP 250

cc: Individual’s File

Individual’s Surrogate [if applicable]

Supports Coordinator