ICF/ID or ICF/ORC Re-Evaluation LOC – Additional information required

DATE

Individual’s or Surrogate’s Name

Address

Address

Dear [Name of Individual or Surrogate]:

You are receiving this letter because the AE is currently conducting a re-evaluation of your Level of Care to determine if you meet continued eligibility for participation in the Office of Developmental Program’s Home and Community Based Waiver Program/Targeted Supports Management (TSM). Upon review it has been determined that additional information is required to make this determination.

The following documentation is being requested as part of the formal Level of Care evaluation process. Please send this office only the items that are checked below:

□ The results of a medical evaluation completed within the previous 365 calendar days that reflects the individual’s current medical condition. A medical form is enclosed with this letter. A recommendation for ICF/ID or ICF/ORC Level of Care must be made by the practitioner.

□ The results of standardized assessment of adaptive functioning (either the Vineland Adaptive Behavior Scales, or the Adaptive Behavior Assessment System-III) that includes the sub-domain scores and shows the individual has substantial functional limitation in three or more of the following areas of major life activity:

* Self-care
* Understanding and use of language
* Learning
* Mobility
* Self-direction
* Capacity for independent living

□ Documentation that the:

* Individual is 21 years of age or younger if the individual may have a developmental disability due to a medically complex condition;
* Individual is 8 years of age or younger if there is a diagnosis of a developmental disability;

Upon receipt of all requested documentation the formal determination process will continue. You may be contacted during the course of this review should questions arise.

The determination of ICF/ID or ICF/ORC level of care will be documented on DP 251 titled Annual Re-evaluation of Need for the ICF/ID or ICF/ORC and sent to you upon completion*.* In addition, the determination of ICF/ORC level of care will be shared with your local County Assistance Office as part of the Medicaid eligibility process.

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

Sincerely,

Name

Waiver Coordinator

Administrative Entity

cc: Individual’s File

Individual’s Surrogate [if applicable]

Supports Coordinator