## Level of Care Re-evaluation/Not Eligible – Results of review

DATE

Individual’s or Surrogate’s Name

Address

Address

Dear [Name of Individual or Surrogate]:

This letter is to inform you that the \_\_\_\_\_\_\_AE conducted an annual Level of Care re-evaluation to determine \_\_\_\_\_\_\_\_\_\_\_\_\_’s (participant’s name) continued eligibility for participation in the Office of Developmental Program’s Home and Community Based Waiver Program/Targeted Supports Management (TSM). This letter provides you notice that you **did not** meet the ICF/ID or ICF/ORC Level of Care requirements. The reason you failed to meet the requirement is indicated as follows:

*Please check*

* Failure to submit requested document/s – Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Failure to meet Level of Care – Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A completed DP 251 titled *Annual Re-evaluation of Need for the ICF/ID or ICF/ORC is* enclosed with this correspondence. Your ICF/ID or ICF/ORC Level of Care determination was communicated to your local County Assistance Office. You will receive a notice from them.

If you disagree with this decision, you have the right to appeal the decision and request a Fair Hearing. These rights and a copy of the Fair Hearing 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 Human Services, Bureau of Hearings and Appeals.

If you have any questions, please contact me at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Sincerely,

Enclosure

DP251

DP 458

cc: Supports Coordinator