## Level of Care Re-evaluation/Eligible for ICF/ID or ICF/ORC – 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 a Level of Care re-evaluation to determine \_\_\_\_\_\_\_\_\_\_\_\_\_’s (participant’s name) continued eligibility for participation in the Home and Community Based Waiver Program/Targeted Supports Management (TSM). This letter confirms that you have met the ICF/ID or ICF/ORC Level of Care requirements. A completed DP 251 titled *Annual Re-evaluation of* *Need for ICF/ID or ICF/ORC Level of Care* is enclosed with this correspondence.

For your future reference, it is a requirement that a Level of Care determination be completed annually. Additionally, the County Assistance Office may request at any time financial information necessary to determine your ongoing eligibility for Medical Assistance. Failure to respond timely to these requests will result in a “not eligible” determination and termination from either the Waiver program/TSM and/or Medical Assistance. All termination notices will be sent from the County Assistance Office via a PA 162 Form.

Sincerely,

Enclosure

DP 251

cc: Supports Coordinator