TITLE: CERTIFICATION OF NEED FOR ICF/ID OR ICF/ORC LEVEL OF CARE

This application is from the Department of Human Services, Office of Developmental Programs. If you need language assistance, free of charge, please call 1-888-565-9435.

Esta solicitud es de la Oficina de Programas de Desarrollo del Departamento de Servicios Humanos. Si necesita ayuda gratuita con el idioma, por favor llame al 1-888-565-9435.

Настоящее заявление направлено из Отдела программ для лиц с пороками развития Департамента социального обеспечения. Если вам требуется бесплатная помощь переводчика, обращайтесь по телефону 1-888-565-9435.

本申请来自发展计划办公室公共事业部。如果您需要语言帮助，请拨打免费电话 1-888-565-9435。

ពាក្យសុំនេះមកពីក្រសួងសេវាកម្មពលរដ្ឋ នៃការិយាល័យកម្មវិធីអភិវឌ្ឍ។ ប្រសិនបើលោកអ្នកត្រូវការជំនួយភាសាដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទលេខ 1-888-565-9435 ។

Đơn xin này từ Bộ Dịch Vụ Nhân Sinh, Văn Phòng Chương Trình Phát Triển. Nếu quý vị cần trợ giúp ngôn ngữ miễn phí, xin vui lòng gọi 1-888-565-9435.

FUNDING SOURCE: ☐ HCBS waiver ☐ ICF

I. PURPOSE. THE PURPOSE OF THIS FORM IS TO CERTIFY WHETHER THE FOLLOWING NAMED INDIVIDUAL REQUIRES AN ICF/ID OR ICF/ORC LEVEL OF CARE FOR DETERMINING ELIGIBILITY FOR HOME AND COMMUNITY SERVICES FUNDED UNDER THE CONSOLIDATED WAIVER, PERSON/FAMILY DIRECTED SUPPORT WAIVER, COMMUNITY LIVING WAIVER, TARGETED SUPPORT MANAGEMENT FOR INDIVIDUALS WHO REQUIRE AN ICF/ORC LEVEL OF CARE, OR FOR ADMISSION TO AN ICF/ID OR ICF/ORC FACILITY.

INDIVIDUAL'S NAME:		
CURRENT ADDRESS:		
CITY:	STATE:	ZIP:
DATE OF BIRTH: (*MM/DD/YYYY*)	MCI #:	TELEPHONE NUMBER: ( )

II. QUALIFIED DEVELOPMENTAL DISABILITY PROFESSIONAL CERTIFICATION. (COMPLETE SECTION A IF THE INDIVIDUAL MEETS ICF/ID OR ICF/ORC LEVEL OF CARE CRITERIA OR SECTION B IF THE INDIVIDUAL DOES NOT. PLEASE CHECK THE BOX FOR EITHER ICF/ID OR ICF/ORC WHEN COMPLETING A.1. OR WHEN COMPLETING B.

A. I HEREBY CERTIFY THAT THIS INDIVIDUAL:

1. HAS COMPLETED ALL STANDARDIZED ASSESSMENTS AND PSYCHOLOGICAL, SOCIAL, AND MEDICAL EVALUATIONS NECESSARY TO DETERMINE NEED FOR AN ☐ ICF/ID OR ☐ ICF/ORC LEVEL OF CARE IN ACCORDANCE WITH CRITERIA ESTABLISHED BY THE DEPARTMENT OF HUMAN SERVICES, OFFICE OF DEVELOPMENTAL PROGRAMS.

and

2. WILL BENEFIT FROM CONSISTENT IMPLEMENTATION OF A PROGRAM OF SPECIALIZED AND GENERIC TRAINING, TREATMENT AND HEALTH OR RELATED SERVICES, DIRECTED TOWARD HELPING THE PERSON FUNCTION WITH AS MUCH SELF-DETERMINATION AND INDEPENDENCE AS POSSIBLE.

QDDP SIGNATURE _____ DATE _____

ADDRESS _____ ( ) TELEPHONE NUMBER

B. I HEREBY CERTIFY THAT THIS INDIVIDUAL DOES NOT REQUIRE AN ☐ ICF/ID OR ☐ ICF/ORC LEVEL OF CARE BASED ON THE CRITERIA ESTABLISHED BY THE DEPARTMENT OF HUMAN SERVICES, OFFICE OF DEVELOPMENTAL PROGRAMS.

QDDP SIGNATURE _____ DATE _____

ADDRESS _____ ( ) TELEPHONE NUMBER

III. CONCURRENCE BY THE DEPARTMENT OF HUMAN SERVICES DESIGNEE THAT IS THE COUNTY MH/ID PROGRAM OR ADMINISTRATIVE ENTITY.

THE COUNTY MH/ID PROGRAM OR ADMINISTRATIVE ENTITY CONCURS WITH THE DETERMINATION OF THE QDDP THAT THE INDIVIDUAL REQUIRES THE IDENTIFIED ICF LEVEL OF CARE.

COUNTY MH/ID PROGRAM OR ADMINISTRATIVE ENTITY SIGNATURE _____ DATE _____

THE COUNTY MH/ID PROGRAM OR ADMINISTRATIVE ENTITY DOES NOT CONCUR WITH THE DETERMINATION OF THE QDDP THAT THE INDIVIDUAL REQUIRES THE IDENTIFIED ICF LEVEL OF CARE.

COUNTY MH/ID PROGRAM OR ADMINISTRATIVE ENTITY SIGNATURE _____ DATE _____

ADDRESS _____ ( ) TELEPHONE NUMBER