TITLE: ANNUAL RECERTIFICATION 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 INDIVIDUAL WHO IS RECEIVING 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 RECEIVING SERVICES IN AN ICF/ID OR ICF/ORC IS DETERMINED TO CONTINUE TO QUALIFY FOR AN ICF/ID OR ICF/ORC LEVEL OF CARE IN ACCORDANCE WITH STATE AND FEDERAL REQUIREMENTS.

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

II. QUALIFIED DEVELOPMENTAL DISABILITY PROFESSIONAL CERTIFICATION

THE ANNUAL RE-EVALUATION OF NEED FOR AN ICF/ID OR ICF/ORC LEVEL OF CARE IS MADE BY THE FOLLOWING NAMED QUALIFIED DEVELOPMENTAL DISABILITY PROFESSIONAL BASED ON THE COMPLETION OF THE WAIVER RE-EVALUATION PROCESS, AS WELL AS A REVIEW OF THE BENEFIT THE INDIVIDUAL IS RECEIVING FROM HOME AND COMMUNITY SERVICES AND SUPPORTS OR CONTINUED STAY IN AN ICF/ID OR ICF/ORC. SECTION A IS COMPLETED IF THE INDIVIDUAL CONTINUES TO QUALIFY FOR AN ICF/ID OR ICF/ORC LEVEL OF CARE OR SECTION B IS COMPLETED IF THE INDIVIDUAL DOES NOT MEET THE CRITERIA.

A. I CERTIFY AS A QUALIFIED DEVELOPMENTAL DISABILITY PROFESSIONAL THAT THE ABOVE NAMED INDIVIDUAL CONTINUES TO QUALIFY FOR AN ☐ **ICF/ID** OR ☐ **ICF/ORC** LEVEL OF CARE. (PLEASE CHECK THE BOX FOR EITHER ICF/ID OR ICF/ORC.)

QDDP SIGNATURE _____ DATE _____

ADDRESS _____ ( ) TELEPHONE NUMBER _____

B. I CERTIFY AS A QUALIFIED INTELLECTUAL DISABILITY PROFESSIONAL THAT THE ABOVE NAMED INDIVIDUAL DOES NOT CONTINUE TO QUALIFY FOR AN ☐ **ICF/ID** OR ☐ **ICF/ORC** LEVEL OF CARE. (PLEASE CHECK THE BOX FOR EITHER ICF/ID OR ICF/ORC)

QDDP SIGNATURE _____ DATE _____

ADDRESS _____ ( ) TELEPHONE NUMBER _____

III. LEVEL OF CARE DETERMINATION

THIS SECTION IS SIGNED BY THE DEPARTMENT DESIGNEE THAT IS THE COUNTY MH/ID PROGRAM OR ADMINISTRATIVE ENTITY.

A. 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 _____

B. 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 _____