

**CERTIFICATION OF NEED FOR INFANTS, TODDLERS & FAMILIES WAIVER**

PURPOSE: THIS FORM IS TO CERTIFY WHETHER THE FOLLOWING NAMED INDIVIDUAL REQUIRES THE ICF/MR/ORC LEVEL OF CARE FOR DETERMING ELIGIBILITY FOR THE MEDICAID WAIVER FOR INFANTS, TODDLERS & FAMILIES.

INDIVIDUAL'S NAME:	PARENT/LEGAL GUARDIAN:	
CURRENT ADDRESS:		
DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	ACCESS NUMBER:

I. QUALIFIED PROFESSIONAL CERTIFICATION (COMPLETE SECTION A IF THE INDIVIDUAL MEETS ICF/MR/ORC LEVEL OF CARE CRITERIA REQUIRED FOR WAIVER FUNDED IFSP SERVICES OR SECTION B IF THE INDIVIDUAL DOES NOT).

I HEREBY CERTIFY THAT THIS INDIVIDUAL:

HAS COMPLETED ALL SCREENINGS, EVALUATIONS AND/OR ASSESSMENTS NECESSARY TO DETERMINE NEED FOR THE ICF/MR/ORC LEVEL OF CARE ESTABLISHED BY THE DEPARTMENT OF PUBLIC WELFARE FOR ENROLLMENT IN THE MEDICAID WAIVER FOR INFANTS, TODDLERS & FAMILIES.

and

A. NEEDS ICF/MR/ORC LEVEL OF CARE BASED ON CRITERIA ESTABLISHED BY THE DEPARTMENT OF PUBLIC WELFARE.

SIGNATURE	DATE
ADDRESS	TELEPHONE NUMBER

or

B. DOES NOT NEED ICF/MR/ORC LEVEL OF CARE BASED ON THE CRITERIA ESTABLISHED BY THE DEPARTMENT OF PUBLIC WELFARE.

SIGNATURE	DATE
ADDRESS	TELEPHONE NUMBER

II. DETERMINATION BY THE DEPARTMENT OF PUBLIC WELFARE DESIGNEE, THE COUNTY MH/MR PROGRAM, COUNTY MH/MR PROGRAM NAME: \_\_\_\_\_ THIS INDIVIDUAL IS DETERMINED TO REQUIRE ICF/MR/ORC LEVEL OF CARE.

COUNTY MH/MR PROGRAM SIGNATURE	TELEPHONE NUMBER
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THIS INDIVIDUAL IS NOT DETERMINED TO REQUIRE ICF/MR/ORC LEVEL OF CARE

COUNTY MH/MR PROGRAM SIGNATURE	TELEPHONE NUMBER
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MH/MR PROGRAM USE ONLY:	WAIVER EFFECTIVE DATE REQUEST:	
CAO USE ONLY:	FAC CODE: 70	DATE:

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