

DATE

Individual's or Surrogate's Name
Address
Address

Dear [Name of Individual or Surrogate]:

This letter is to inform you that funds are available to enroll [Name of Individual] in the [Name of Waiver] Waiver.

[Name of Individual] had been determined "likely to meet" the level of care requirements of an Intermediate Care Facility for the Mentally Retarded (ICF/MR) during the Service Delivery Preference process. The level of care criteria must now be validated before Waiver enrollment can be finalized. The verification of ICF/MR level of care must be completed by [a date 45 calendar days in the future] to meet Waiver requirements.

A Qualified Mental Retardation Specialist (QMRP) must certify that [Name of Individual] requires active treatment, has a diagnosis of mental retardation, and is recommended for an ICF/MR level of care based on a medical evaluation. The QMRP of [Name of County Program or Administrative Entity] who will certify ICF/MR level of care is Name of QMRP]. You may be contacted directly by the QMRP as part of the verification process.

The following documentation is required as part of the verification process. Please send this office only the items that are checked below:

- The results of a medical evaluation completed within the previous 365 calendar days that reflects the individual's current medical condition. The medical evaluation may be completed on the medical evaluation approved by the Department (Form MA 51, enclosed), or may be another examination that is completed by a licensed physician, physician's assistant, or nurse practitioner.
- The results of a standardized intelligence test conducted by a licensed psychologist, certified school psychologist, psychiatrist, or licensed physician who practices psychiatry that shows a full scale I.Q. of approximately 70 or below.

