DATE

Individual’s or Surrogate’s Name
Address
Address

Dear [Name of Individual or Surrogate]:

A letter dated __[Date of 1st letter]__ was sent to you 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 be validated before Waiver enrollment can be finalized.

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.

All documentation that is checked below must be received in this office by __[a date 10 calendar days in the future]__ to verify the ICF/MR level of care and to meet Waiver requirements. If the documentation is not received by the deadline, __[Name of Individual]__ will lose the opportunity for enrollment in the Waiver at this time but will continue to hold a place on the waiting list.

☐ 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.
☐ The results of an adaptive behavior skills standardized assessment (for example, the Vineland Adaptive Behavior Scales) that shows one of the following:
  - Significant limitation in meeting the standards of maturation, learning, personal independence, or social responsibility
  - Substantial functional limitation in three or more of the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency.

☐ Documentation that substantiates that these conditions of intellectual and adaptive functioning manifested before the individual reached 22 years of age.

☐ Documentation that a diagnosis of mental retardation was made or confirmed by a licensed clinician.

When all of the documentation has been received at our office, the QMRP will verify the need for ICF/MR level of care. If questions remain regarding the ICF/MR level of care verification after the review of the available records and history, the QMRP may choose to request a face-to-face meeting with the individual, family, or surrogate decision maker.

The QMRP’s decision regarding the verification of ICF/MR level of care will be documented on form DP 250, “Certification of Need for ICF/MR Level of Care”. A copy of the DP 250 form will be sent to you once it is completed. In addition, the determination of ICF/MR level of care will be shared with your local County Assistance Office as part of the Medicaid eligibility process for Waiver enrollment.

Please work with the QMRP to complete this important step of the Waiver enrollment process. If you have any questions regarding this letter, please contact me at (Telephone Number).

Sincerely,

Name
Waiver Coordinator
County MH/MR Program or Administrative Entity

Enclosure
  MA 51, Medical Evaluation

cc: Individual’s File
  Individual’s Surrogate [if applicable]
  Individual’s Supports Coordinator