

DATE

Individual's or Surrogate's Name
Address
Address

Dear [Name of Individual or Surrogate]:

A letter dated ___ [Date of Letter]___ was sent informing you that additional information was required to conduct the verification of the need for a level of care normally provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) for ___ [Name of Individual]___ as part of the Waiver enrollment process. The information was to be received at this office by ___ [deadline date given]___.

To date, this office has not received all of the required information to determine the need for ICF/MR level of care to enroll ___ [Name of Individual]___ in the ___ [Name of Waiver]___ Waiver. As a result, this office has discontinued the Waiver enrollment process. ___ [Name of Individual]___'s name will be kept on the waiting list for future enrollment in the Waiver should funding become available.

If you have any questions regarding this letter, please contact your Supports Coordinator at ___ [Telephone Number]___.

Sincerely,

Name
MR Director
County MH/MR Program or Administrative Entity

cc: Individual's File
Individual's Surrogate [if applicable]
Supports Coordinator
ODP Waiver Coordinator