Dear [Name of Individual or Surrogate]:

An evaluation was recently conducted by a Qualified Mental Retardation Professional (QMRP) to determine whether ___(Name of Individual)___ requires a level of care normally provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). This evaluation is required as part of the process to enroll ___(Name of Individual)___ in the ___(Name of Waiver)___ Waiver. This letter is to notify you of the decision that was made by the QMRP who conducted the review.

As explained to you in the letter of ___(Date of Letter)___, the QMRP reviewed available histories and information in order to certify that ___(Name of Individual)___ has a diagnosis of mental retardation, requires active treatment, and is recommended for an ICF/MR level of care.

The QMRP has determined that ___(Name of Individual)___ meets the ICF/MR level of care requirements necessary to be enrolled in the ___(Name of Waiver)___ Waiver. Enclosed is a completed and signed copy of form DP 250, “Certification of Need for ICF/MR level of Care”, that certifies and documents that ___(Name of Individual)___ meets this requirement.

The ICF/MR level of care decision was communicated to your local County Assistance Office. You will receive a notice from that office as part of the Medicaid Waiver eligibility determination 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
    DP 250, “Certification of Need for ICF/MR level of Care”

cc: Individual’s File
    Individual’s Surrogate (if applicable)
    Individual’s Supports Coordinator