

TITLE: CERIFICATION OF NEED FOR ICF/MR LEVEL OF CARE

I. PURPOSE. THE PURPOSE OF THIS FORM IS TO CERTIFY WHETHER THE FOLLOWING NAMED INDIVIDUAL REQUIRES AN ICF/MR LEVEL OF CARE FOR DETERMINING ELIGIBILITY FOR HOME AND COMMUNITY SERVICES FUNDED UNDER THE 2176 WAIVER.

INDIVIDUAL'S NAME:

CURRENT ADDRESS:

DATE OF BIRTH

SOCIAL SECURITY NUMBER:

II. QUALIFIED MENTAL RETARDATION PROFESSIONAL CERTIFICATION. (COMPLETE SECTION A IF THE INDIVIDUAL MEETS ICF/MR LEVEL OF CARE CRITERIA OR SECTION B IF THE INDIVIDUAL DOES NOT.)

A. I HEREBY CERTIFY THAT THIS INDIVIDUAL:

a). HAS COMPLETED ALL STANDARDIZED ASSESSMENTS AND PSYCHOLOGICAL, SOCIAL AND MEDICAL EVALUATIONS NECESSARY TO DETERMINE NEED FOR AN ICF/MR LEVEL OF CARE IN ACCORDANCE WITH CRITERIA ESTABLISHED BY THE DEPARTMENT OF PUBLIC WELFARE, OFFICE OF MENTAL RETARDATION.

and

b). WILL BENEFIT FROM A PROFESSIONALLY DEVELOPED AND SUPERVISED PORGRAM OF SERVICES AND SUPPORTS WHICH ARE NECESSARY FOR THE INDIVIDUAL TO FUNCTION AT HIS/HER GREATEST PHYSICAL, INTELLECTUAL, SOCIAL OR VOCATIONAL POTENTIAL OR TO PREVENT REGRESSION OR LOSS OF CURRENT OPTIMAL FUNCTIONAL STATUS.

SIGNATURE DATE

ADDRESS TELEPHONE NUMBER

B. I HEREBY CERTIFY THAT THIS INDIVIDUAL DOES NOT REQUIRE AN ICF/MR LEVEL OF CARE BASED ON THE CRITERIA ESTABLISHED BY THE DEPARTMENT OF PUBLIC WELFARE, OFFICE OF MENTAL RETARDATION.

SIGNATURE DATE

ADDRESS TELEPHONE NUMBER

III. DETERMINATION BY THE DEPARTMENT OF PUBLIC WELFARE DESIGNEE, THE COUNTY MH/MR PROGRAM.

THIS INDIVIDUAL IS DETERMINED TO REQUIRE AN ICF/MR LEVEL OF CARE.

COUNTY MH/ MR PROGRAM SIGNATURE DATE

THIS INDIVIDUAL IS DETERMINED TO NOT REQUIRE AN ICF/MR LEVEL OF CARE

COUNTY MH/ MR PROGRAM SIGNATURE DATE

ADDRESS TELEPHONE NUMBER