

MAILING DATE

Individual's or Surrogate's Name
Address
Address

Dear [Name of Individual or Surrogate]:

Thank you for your recent inquiry in regards to registering for services through the [Name of County MH/MR Program] . In order to determine that [Name of Individual] is eligible for mental retardation services and to continue with the intake and registration process, please supply the information that is checked below:

- Release of Records request (2 copies). Please sign these forms and return one copy to us by [Date 10 calendar days from mailing date of letter] . A self-addressed envelope is enclosed for your convenience.
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) Notice of Privacy Practices. Please review this document and return the completed signature page to us by [Date 10 calendar days from mailing date of letter] .
- 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 less. This information should be received in our office by [Date 30 calendar days from date of letter] .
- The results of an adaptive behavior skills standardized assessment that shows one of the following:
 - Significant limitation in meeting the standards of maturation, learning, or social adjustment.
 - Substantial functional limitation in two or more of the areas of communication, self-care, home living, social and interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.This information should be received in our office by [Date 30 calendar days from mailing date of letter] .
- Documentation that substantiates that these conditions of intellectual and adaptive functioning manifested before the individual reached 22 years of age. This information should be received in our office by [Date 30 calendar days from mailing date of letter] .

- Documentation that a diagnosis of mental retardation was made or confirmed by a licensed clinician. This information should be received in our office by [Date 30 calendar days from mailing date of letter] .
- A copy of the following checked documents:
- Social Security Card.
 - Birth Certificate.
 - Medical Assistance Card.
 - Third Party Insurance Cards.
 - Legal Guardian or Custodial Documents.
 - Proof of Citizenship.

The intake process cannot continue unless the requested information is received by our office. A self-addressed envelope is enclosed for your convenience in mailing the required documents. Or, if you prefer, the results may be faxed to our office at (Telephone Number) .

If you have any questions regarding this letter, please contact me at (Telephone Number) .

Sincerely,

Name
Intake Officer
County MH/MR Program

Enclosures
Release of Records request (2 copies)
HIPAA Notice of Privacy Practices
Self-Addressed Envelopes [2]

cc: Individual's File
Individual's Surrogate [if applicable]
Intake Supervisor