

Date

(Individual's Name or Surrogate's Name)  
(Address)  
Address)

Dear (Name of Individual or Surrogate) :

This letter is to advise that (Name of Individual) has been determined to be likely to meet ICF/MR level of care and other Medical Assistance eligibility requirements that would qualify (Name of Individual) to receive funding for home and community services under a Medicaid Waiver. This is based on a preliminary determination of eligibility for ICF/MR level of care and will be subject to formal review before Waiver enrollment can be finalized. Feasible alternatives to home and community based services were reviewed with you so that an informed decision could be made regarding service delivery preference. A copy of the completed Home and Community-Based or ICF/MR Application and Service Delivery Preference Form (DP 457) is enclosed. This form will be kept on file in the event funding becomes available to enroll (Name of Individual) in the Waiver.

Funds are not available to enroll (Name of Individual) in a Medicaid Waiver at this time. Medicaid Waiver funding is allocated to the County MH/MR Program or Administrative Entity (AE) from the Pennsylvania Department of Public Welfare. All of the Medicaid Waiver funding for this year is committed to support persons receiving services or has already been committed to specific individuals on the Prioritization of Urgency of Need for Services (PUNS) waiting list.

The County MH/MR Program or AE will be completing the following activities to ensure that you receive the services you need as promptly as possible:

- A PUNS form will be completed to document your current unmet need for services or anticipated need for services in the future. If you already have had a PUNS completed, the PUNS will be updated if your needs change substantially. The PUNS will be used by the Department of Public Welfare's Office of Developmental Programs and the County or AE when funding becomes available for services and in planning for future need.
- To assist you and your family, other sources of service funding will be identified based on their availability.

Under State and Federal rules, you have certain fair hearing rights afforded to you at this time. These rights and a copy of the Fair Hearing and Appeal Instructions and Request Form (DP 458) are enclosed.

If you have any questions about this information, please contact your Supports Coordinator, (Name of Supports Coordinator) at (Phone Number).

Your Supports Coordinator can answer questions about your PUNS and any new funding requests on your behalf.

Thank you for your attention to this matter.

Sincerely,

(Name)

Administrative Entity or County MH/MR Program

Enclosures

DP 457, Home and Community-Based or ICF/MR Application and Service  
Delivery Preference Form

DP 458, Fair Hearing Request Form

cc: MR Director  
SC Entity Director  
Supports Coordinator  
File (Individual's)