

Date

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

Dear (Name of Individual or Surrogate) :

This letter is to confirm that  (Name of Individual)  is "likely to be eligible" for ICF/MR level of care. The opportunity to select a service delivery preference option on form DP 457 was presented to you on  (Date) . Feasible alternatives were reviewed with you at that time so that an informed decision could be made regarding service delivery preference. However, no service delivery preference option was chosen for  (Name of Individual) . A copy of your Home and Community-Based or ICF/MR Application and Service Delivery Preference Form (DP 457) is enclosed. You indicated you are not interested in proceeding with the Service Delivery Preference Process at this time.

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.

You may indicate a service delivery preference option for  (Name of Individual)  at any time. If you wish to apply for a Medicaid Waiver or placement in an Intermediate Care Facility for the Mentally Retarded for  (Name of Individual) , please contact me to continue the service delivery preference process.

Sincerely,

(Name)  
County MH/MR Program or Administrative Entity

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)