

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

This application is from the Department of Public Welfare, Office of Developmental Programs. If you need language assistance, free of charge, please call 1-888-565-9435.

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Esta solicitud es del Departamento de Bienestar Público, Oficina de Programas de Desarrollo. Si necesita ayuda con el idioma, gratis, llame por favor al 1-888-565-9435.

Настоящее заявление – от Бюро программ развития Отдела социального обеспечения (Department of Public Welfare). Если вам нужна помощь переводчика, звоните по телефону 1-888-565-9435 (бесплатно).

ពាក្យដាក់សុំនេះ ចេញពីក្រសួងសាធារណៈដីលវៃ ការិយាល័យទទួលបន្ទុកលើកម្មវិធីបណ្តុះបណ្តាល។ បើអ្នកត្រូវការជំនួយផ្នែកភាសា ដោយមិនបាច់ចេញលុយ សូមទូរស័ព្ទមក 1-888-565-9435។

Mẫu đơn này là của Sở Trợ Cấp Phúc Lợi Công Cộng, Văn Phòng Phát Triển các Chương Trình. Nếu quý vị muốn được trợ giúp về ngôn ngữ, miễn phí, xin gọi số 1-888-565-9435.

FUNDING SOURCE:

P/FDS WAIVER

CONSOLIDATED WAIVER

ICF/MR

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 CONSOLIDATED OR PERSON/FAMILY DIRECTED SUPPORT WAIVERS OR FOR ADMISSION TO AN ICF/MR.

INDIVIDUAL'S NAME:

CURRENT ADDRESS:

CITY:	STATE:	ZIP:
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DATE OF BIRTH: (MM/DD/YYYY)	SOCIAL SECURITY NUMBER:	TELEPHONE NUMBER: ()
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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:
1. 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 DEVELOPMENTAL PROGRAMS.

and

 2. WILL BENEFIT FROM A PROFESSIONALLY DEVELOPED AND SUPERVISED PROGRAM OF ACTIVITIES, EXPERIENCES, OR THERAPIES THAT ARE NECESSARY FOR ASSISTING THE INDIVIDUAL TO FUNCTION AT HIS OR 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 DEVELOPMENTAL PROGRAMS.

_____ SIGNATURE	_____ DATE
_____ ADDRESS	() TELEPHONE NUMBER

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

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

_____ COUNTY MH/MR PROGRAM OR ADMINISTRATIVE ENTITY SIGNATURE	_____ DATE
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THIS INDIVIDUAL IS DETERMINED TO NOT REQUIRE AN ICF/MR LEVEL OF CARE.

_____ COUNTY MH/MR PROGRAM OR ADMINISTRATIVE ENTITY SIGNATURE	_____ DATE
_____ ADDRESS	() TELEPHONE NUMBER