

DATE

Individual's or Surrogate's Name  
Address  
Address

Dear [Name of Individual or Surrogate]:

A letter dated \_\_\_ [Date of Letter]\_\_\_ was sent informing you that additional information was required to conduct the verification of the need for a level of care normally provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) for \_\_\_ [Name of Individual]\_\_\_ as part of the Waiver enrollment process. The information was to be received at this office by \_\_\_ [deadline date given]\_\_\_.

To date, this office has not received all of the required information to determine the need for ICF/MR level of care to enroll \_\_\_ [Name of Individual]\_\_\_ in the \_\_\_ [Name of Waiver]\_\_\_ Waiver. As a result, this office has discontinued the Waiver enrollment process. \_\_\_ [Name of Individual]\_\_\_'s name will be kept on the waiting list for future enrollment in the Waiver should funding become available.

If you have any questions regarding this letter, please contact your Supports Coordinator at \_\_\_ [Telephone Number]\_\_\_.

Sincerely,

Name  
MR Director  
County MH/MR Program or Administrative Entity

cc: Individual's File  
Individual's Surrogate [if applicable]  
Supports Coordinator  
ODP Waiver Coordinator