Dear [Name of Individual or Surrogate]:

An evaluation was recently conducted by a Qualified Mental Retardation Professional (QMRP) to determine whether ___(Name of Individual)___ requires a level of care normally provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). This evaluation is required as part of the process to enroll ___(Name of Individual)___ in the _(Name of Waiver)___ Waiver. This letter is to notify you of the decision that was made by the QMRP who conducted the review.

As explained to you in the letter of __(Date of Letter)__ , the QMRP reviewed available histories and information in order to certify that ___(Name of Individual)___ has a diagnosis of mental retardation, requires active treatment, and is recommended for an ICF/MR level of care.

The QMRP has determined that ___(Name of Individual)___ does not meet the ICF/MR level of care requirements necessary to be enrolled in the ___[Name of Waiver]___ Waiver. The reasons for this decision are as follows:

______________________________

Enclosed is a completed and signed copy of form DP 250, “Certification of Need for ICF/MR level of Care”, that certifies and documents that ___(Name of Individual)___ does not meet the level of care requirements. The ICF/MR level of care decision was communicated to your local County Assistance Office. You will also receive a notice from that office as part of the Medicaid Waiver eligibility determination process.

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. The appeal must be postmarked by ____[Date 30 calendar days in the future]___ to be heard by the Department of Public Welfare, Bureau of Hearings and Appeals.

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

Sincerely,
Name
Waiver Coordinator
County MH/MR Program or Administrative Entity

Enclosures
- DP 250, "Certification of Need for ICF/MR level of Care"
- DP 458, Fair Hearing Request Form

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