RECERTIFICATION OF NEED FOR INFANTS, TODDLERS AND FAMILIES WAIVER

PURPOSE: This form is to recertify whether the following named individual requires the ICF/ID/ORC level of care for determining eligibility for the Medicaid Waiver for Infants, Toddlers and Families.

INDIVIDUAL'S NAME:		PARENT/LEGAL GUARDIAN:
CURRENT ADDRESS:		
DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	ACCESS NUMBER:

Parent/Legal Guardian Information

TELEPHONE NUMBER:	CELL NUMBER:	EMAIL:

I. QUALIFIED PROFESSIONAL CERTIFICATION (Complete Section A if the individual meets ICF/ID/ORC level of care criteria required for waiver funded IFSP services, or Section B if the individual does not.)

I hereby certify that this individual has completed all evaluations and/or assessments necessary to determine need for the ICF/ID/ORC level of care established by the Department of Human Services for enrollment in the Medicaid Waiver for Infants, Toddlers and Families.

and

A. Continues to need ICF/ID/ORC level of care based on criteria established by the Department of Human Services.

_____ _____
(SIGNATURE) DATE

_____ _____
(ADDRESS) (TELEPHONE NUMBER)

or

B. Does not require ICF/ID/ORC level of care based on criteria established by the Department of Human Services.

_____ _____
(SIGNATURE) DATE

_____ _____
(ADDRESS) (TELEPHONE NUMBER)

II. DETERMINATION by the Department of Human Services designee, the county MH/ID program.

_____
(NAME OF COUNTY MH/ID PROGRAM)

This individual is determined to require ICF/ID/ORC level of care.

_____ _____ _____
(COUNTY MH/ID PROGRAM SIGNATURE) (DATE) (TELEPHONE NUMBER)

This individual is determined not to require ICF/ID/ORC level of care.

_____ _____
(COUNTY MH/ID PROGRAM SIGNATURE) DATE

MH/ID PROGRAM USE ONLY	WAIVER EFFECTIVE DATE REQUEST:	
CAO USE ONLY:	FAC CODE:	DATE: