

CERTIFICATION OF NEED FOR INFANTS, TODDLERS AND FAMILIES WAIVER

PURPOSE: This form is to certify 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:
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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 screenings, 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. Needs 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 need 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)
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This individual is not determined to require ICF/ID/ORC level of care.

(COUNTY MH/ID PROGRAM SIGNATURE)	DATE
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MH/ID PROGRAM USE ONLY	WAIVER EFFECTIVE DATE REQUEST:	
CAO USE ONLY:	FAC CODE:	DATE: