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.

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.

ពាក្យសុំនេះចេញពីក្រសួងសាធារណៈជីលរបៀ ការិយាល័យទទួលបន្ទុកលើកម្មវិធីបណ្តុះបណ្តាល។ បើលោកអ្នកត្រូវការជំនួយផ្នែកភាសា ដោយមិនបាច់ចេញលុយ សូមទូរស័ព្ទមក 1-888-565-9435។

这是公共福利部发展计划办公室提供的申请书．你如果需要语言方面的免费协助，请致电 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).

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.

HOME AND COMMUNITY-BASED OR ICF/MR APPLICATION AND SERVICE DELIVERY PREFERENCE FORM

I. CONFIRMATION OF UNDERSTANDING

I, _____ , have been informed of the following:
(NAME OF INDIVIDUAL)

a. That I am likely to require the level of care provided in an Intermediate Care Facility for people with Mental Retardation (ICF/MR). **I understand that this is based on a preliminary determination of eligibility for ICF/MR level of care, and that the determination will be subject to formal review.**

b. About feasible home and community-based service alternatives to services provided in an ICF/MR

c. About my right to indicate a preference for home and community-based services funded under the Waiver as an alternative to services provided in an ICF/MR and about my rights to a fair hearing before the Department of Public Welfare, Bureau of Hearings and Appeals.

In declaring my preference for home and community-based services funded under the Waiver or ICF/MR,
I, _____ , understand the following:
(NAME OF INDIVIDUAL)

a. That I must meet Department of Public Welfare eligibility standards to receive services funded by the Waiver or ICF/MR.

b. That a fair hearing and appeal will not be granted if I am appealing changes caused solely by state or federal law or regulation requiring a change in the type of services available.

c. That completion of Service Delivery Preference does not guarantee services. Availability of State and Federal funds control the allocated resources for individuals to be served in the Waiver.

II. DESIGNATION OF SERVICE PREFERENCE

My service preference is: (initials or mark of individual, surrogate, or QMRP beside one option)

☐ Home and community-based services funded under the Waiver

☐ Services in an ICF/MR

☐ None at this time (If this option is chosen, Section III. does not apply.)

III. APPLICATION

Please indicate agreement and understanding of the following: (initials or mark of individual, surrogate, or QMRP beside each option)

☐ I, _____ , hereby make application to be considered for the above indicated services for individuals with mental retardation.
(NAME OF INDIVIDUAL)

☐ I, _____ , understand that by submission of this application, I can expect a formal assessment of my need for services by the County/Administrative Entity.
(NAME OF INDIVIDUAL)

IV. PARTICIPANT INFORMATION AND SIGNATURES

A. Individual. (This section must be completed for the individual who is requesting services).

INDIVIDUAL NAME:			
ACCESS NUMBER:			
CURRENT STREET ADDRESS:			
CITY:	STATE:	ZIP:	TELEPHONE NUMBER: ( )
SIGNATURE:		DATE:	

B. Surrogate. (This section must be completed when the individual's surrogate signifies the preference for Waiver or ICF/MR services on the individual's behalf.)

NAME:			
STREET ADDRESS:			
CITY:	STATE:	ZIP:	TELEPHONE NUMBER: ( )
SIGNATURE:		DATE:	

C. Independent Qualified Mental Retardation Professional. (This section must be completed by the independent qualified mental retardation professional who is responsible to document the individual's preference for Waiver or ICF/MR services).

NAME:			
AGENCY:			
STREET ADDRESS:			
CITY:	STATE:	ZIP:	TELEPHONE NUMBER: ( )
SIGNATURE:		DATE:	

D. County MH/MR Program/Administrative Entity Designee. (This section must be completed by the County MH/MR Program/Administrative Entity that offers the individual or surrogate the preference for Waiver or ICF/MR services).

COUNTY DESIGNEE NAME:			
TITLE:			
AGENCY STREET ADDRESS:			
CITY:	STATE:	ZIP:	TELEPHONE NUMBER: ( )
SIGNATURE:		DATE:	