DODD HCBS Waiver Redetermination:
No Significant Change
APPLICANT INFORMATION

Name _____ **County** _____ **Client #** _____

Date of Birth _____ **Social Security #** _____

Household Mailing Address _____

Guardian _____ **Address** _____

Waiver Type (check one) ☐Individual Option ☐Level 1

LEVEL OF CARE: REDETERMINATION

Waiver Begin Date (mm/dd/yyyy): _____

I certify the following: There has been no substantial change in the individual's condition and the individual has three (3) qualifying functional limitations and continues to meet ICF/DODD Level of Care.

Name: (please print) _____ **Title:** _____

Signature: _____ **Date:** _____

(DODD USE ONLY)

_____
QMRP LOC Approval Signature/Date