

**ODMR/DD 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) <input type="checkbox"/> Individual Option <input type="checkbox"/> 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/MRDD Level of Care.
Name: (please print) _____ Title: _____
Signature: _____ Date: _____
(ODMRDD USE ONLY)
_____ QMRP LOC Approval Signature/Date