DEVELOPMENTAL DISABILITIES ADMINISTRATION
COMMUNITY PATHWAYS WAIVER

LEVEL OF CARE
INITIAL CERTIFICATE OF NEED

This is to certify that _____
(FIRST, MIDDLE, LAST)

Medical Assistance Number: _____

In accordance with DDA eligibility criteria, has been determined to need waiver services and meets the appropriate Level of Care effective: _____.

Verification of a "developmental disability" per the DDA PCIS2 Eligibility Category determined on _____ (*insert date*).

Service Delivery Model: (*check one*)

____Traditional/Provider Managed Services

____Self-Directed Services

____Combination of Traditional and Self-Directed Services

Resource Coordinator: _____ Date: _____
Signature

Resource Coordinator *(printed name)*: _____

DDA Review: _____ Date: _____
Signature