DEPARTMENT OF DEVELOPMENTAL SERVICES WAIVER REFERRAL

COUNTY USE ONLY	
Case name	Case number
Worker name	Worker number

CALIFORNIA REGIONAL CENTER—Please complete this portion and forward to the appropriate County Waiver Contact Person.

Name of applicant

Address (number, street)	City	State	ZIP code
Social Security number	Date of birth	Telephone ( )	

Parent/Guardian (if applicable)

Address of parent/guardian (if different)	City	State	ZIP code

STATUS

- ❒ New Medi-Cal applicant.
- ❒ Currently receives Medi-Cal with a share of cost. Reevaluate under special institutional deeming rules.

LIVING ARRANGEMENT

- ❒ The applicant is currently in an institution. Please determine Medi-Cal eligibility based on his/her anticipated return to the home. Anticipated date of discharge _____.
- ❒ The applicant is currently living in the home.
- ❒ Other: _____

This is to certify that the individual named above has met the admission criteria for an intermediate care facility for the developmentally disabled as defined in the California Health and Safety Code, Chapter 2, Section 1250.

Signature of Regional Center contact person

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Printed name of Regional Center contact person	Title	Telephone ( )	
Regional Center address (number, street)	City	State	ZIP code

NOTE TO COUNTY: The eligibility determination waives parental and spousal income and resources even if the applicant lives in the home. See Section 19D of the Medi-Cal Eligibility Procedures Manual. If the applicant/beneficiary is entitled to zero share of cost Medi-Cal under regular eligibility rules, no waiver is required.

Please send a copy of the Notice of Action to the Regional Center when the determination is completed.

White: County copy *Yellow: Regional Center Copy*