DEVELOPMENTAL DISABILITIES ADMINISTRATION
Home and Community-Based Services Waiver

LEVEL OF CARE
INITIAL CERTIFICATE OF NEED

This is to certify that:_____
(Name: First, Middle, Last) *(LTSS ID)*

has been determined to need waiver services and meets the appropriate Level of Care.

In accordance with DDA eligibility criteria listed below, the above named has a severe chronic disability that:

- Is attributable to a physical or mental impairment, other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments;
- Is manifested before the individual attains the age of 22;
- Is likely to continue indefinitely;
- Results in an inability to live independently without external support or continuing and regular assistance; and
- Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are individually planned and coordinated for the individual.

I verified that the participant has a "Developmental Disability" as noted in their **Eligibility Determination Form** in LTSSMaryland.

Coordinator of Community Services: _____ Date: _____
Signature

Coordinator of Community Services: *(printed name)*: _____