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|  | **Individual Information:** | | |
| ***1.*** | Region: | Name of the Individual:  Medicaid ID Number:  Individual’s Address: |  |
| **Certification Dates (not to exceed 24 months, and should align with HCBS review date):** | | | |
| ***2.*** | 521.09 | Certification Request | Start Date:  End Date: |
| **He-M 521.09 Certification (to be completed by Provider):** | | | |
| ***3.*** | INITIAL:  521.09 | By selecting YES, the signer of this request is attesting that the service agreement and documentation meets the requirements identified in He-M 521.05 and He-M 521.06. | Yes |
| ***4.*** | RENEWAL:  521.09 | By selecting YES, the signer of this request is attesting that the service agreement and documentation meet the requirements identified in He-M 521.05 through He-M 521.08. | Yes |
| ***5.*** | Provider’s signature indicates the provider’s recommendation for certification to the Bureau of Developmental Service: | Date Completed: | Provider Signature: |
| **He-M 521.09 Certification (to be completed by Bureau of Developmental Services):** | | | |
| ***6.*** | 521.09 | Service agreement and individualized budget has been reviewed by the Bureau of Developmental Services. | Yes |
| ***7.*** | BDS signature indicates the acceptance and approval of the provider’s recommendation for certification: | Date Reviewed: | BDS Signature: |