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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.*** | 525.07 | Certification Request  | Start Date:      End Date:       |
| **He-M 525.06 Administrative, Service, and Personnel Requirements (to be completed by Area Agency):** |
| ***3.*** | 525.06 | By selecting YES, the signer of this request is attesting that service arrangement and documentation meets the requirements identified in He-M 525.06. | [ ]  Yes |
| ***4.*** | AA signature indicates the AAs recommendation for certification to the Bureau of Developmental Service: | Date completed:       | Area Agency Signature:      |
| **He-M 525.12 Funding and Payment (to be completed by Bureau of Developmental Services):** |
| ***5.*** | 525.12 (b) | Service Arrangement and Individualized Budget has been reviewed by the Bureau of Developmental Services. | [ ]  Yes |
| ***6.*** | BDS signature indicates the acceptance and approval of the AAs recommendation for certification: | Date reviewed:       | BDS Signature:       |