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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: |