HOME AND COMMUNITY BASED SERVICES I/DD MEDICAID WAIVER INDIVIDUAL CHOICE

Name of Participant Date of Birth

If assessment results indicate that I meet functional eligibility criteria qualifying me for long-term care services that are essential to my health and welfare, I have two choices on where to receive my services. My choices are to receive services in my home or other community-based setting, within cost limitations of the program, or in the institutional equivalent (ICF-IID). I have been informed if I am determined eligible for Home and Community-Based Services (HCBS), I have the option to remain in the community and receive the services designated on my Person-Centered Service Plan.

_____ My initials mean I understand that I am not guaranteed to receive either choice and may be placed on a waiting list, depending upon the availability of either service.

It is my choice to:

_____ Apply for ICF/IID facility placement

_____ Receive HCBS under the Intellectual/Developmental Disability (I/DD) Medicaid waiver when offered.

My signature verifies I have read, or had read *to* me, my rights and responsibilities and have made the choices as indicated. I am also indicating willingness to participate in the design of my Person-Centered Service Plan.

_____

Participant Signature Date

_____

Guardian Signature Date

_____

CDDO Member Signature Date