HOME AND COMMUNITY BASED SERVICES
MR/DD MEDICAID WAIVER
CONSUMER CHOICE

_____ _____

Consumer Name Social Security Number

IF assessment results indicate I meet eligibility criteria for Intermediate Care Facility for the Mentally Retarded (ICF/MR) qualifying me for long term care services, then services that are essential to my health and Welfare can be provided to me in my home or other community based setting within cost limitations of the program. I have been informed in the event I am determined eligible for Home and Community Based Services (HCBS), I am eligible to receive services and have the option to remain in the community and receive the services designated on the Plan of Care.

It is my Choice to (Check One):

☐ enter an ICF/MR facility – (Intermediate Care Facility for the Mentally Retarded)

☐ receive HCBS (for Home and Community Based Services) under the Mental Retardation/Developmental Disabilities (MR/DD) Medicaid waiver

☐ refuse services at this time

I further 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.

If I choose to receive HCBS, I understand I have the option to self direct my in-home supports. It is my choice to (Check One):

☐ to self-direct my in-home supports or appoint someone to act in this capacity on my behalf (if choosing this option a Consumer Directed Form (MR-6 must be completed)

☐ not to self-direct my in-home supports

I understand, by choosing HCBS, I am not responsible for payment of Medicaid co-pays.

I have been given my choice of providers and of payroll agents.

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 Plan of care.

_____ _____

Person Served Signature Date

_____ _____

Guardian Signature Date

_____ _____

CDDO Member/Case Manager Date