MR-1
Revised 01/28/98

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

______________________________________ ______________________________
Individual Name Social Security Number

If assessment results indicate I meet entrance 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

________ receive HCBS 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 (check one):

________ to self-direct my in-home supports or appoint someone to act in this capacity on my behalf {if choosing this option an Individual 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 choice as indicated. I am also indicating willingness to participate in the design of my Plan of Care.

______________________________________ ______________________________
Individual Signature Date

______________________________________ ______________________________
Guardian Signature Date

______________________________________ ______________________________
CDDO Member/Case Manager Signature Date