

## FREEDOM OF CHOICE DOCUMENTATION

Name (Last, First, Middle Initial)	County

**A. Selection of HCBS Waiver** (check one)

I understand that enrollment on a Medicaid Home & Community Based Services (HCBS) Waiver is strictly voluntary. I also understand that if enrolled I will be receiving Waiver services instead of services in an Intermediate Care Facility for the Mentally Retarded.

- I have chosen HCBS Waiver Services
- I have not chosen HCBS Waiver Services

**B. Applicant's Responsibilities**

- ❖ I understand the HCBS Waiver must keep the cost of my services below a certain dollar amount for me to be on the Waiver. I understand that I may be required to pay a patient liability to one of my service providers if that is part of my financial eligibility to stay on the Waiver.
- ❖ I understand the HCBS Waiver will deliver services according to my Individual Service Plan (ISP). I will cooperate in a reassessment when my ISP is about to expire.
- ❖ I understand that my ISP will be monitored and reviewed by my Service Support Administrator and that I can contact my Service Support Administrator at any time I have questions about my ISP or the services that I receive.
- ❖ I understand that I have the right to choose the provider for each of my HCBS Waiver services. (An approved provider is one who meets ODMRDD Provider Certification.)

Applicant's Signature/Date
Authorized Representative Signature/Date
Legal Guardian Signature/Date
Service Support Administrator Signature/Date

**Form Distribution**

- Original to official file of applicant at the County Board of MRDD
- Copy to the Consumer, Guardian (if applicable), COG (if applicable)
- Copy to ODMR/DD with Level of Care packet