DIVISION OF HEALTHCARE FACILITIES MANAGEMENT

I. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, ACQUIRED BRAIN INJURY WAIVER

A. HCBS - This is to certify that I/legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS program as an alternative to NF placement is requested ________; is not requested ________.  

_________________________________  
Signature  
_____ / _____ / ________  
Date

B. This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation/ developmental disabilities. Consideration for the waiver program as an alternative to ICF/MR/DD is requested ________; is not requested ________.  

_________________________________  
Signature  
_____ / _____ / ________  
Date

C. MODEL WAIVER II - This is to certify that I/legal representative have been informed of the Model Waiver II program. Consideration for the Model Waiver II program as an alternative to NF placement is requested ________; is not requested ________.  

_________________________________  
Signature  
_____ / _____ / ________  
Date

D. ACQUIRED BRAIN INJURY (ABI) WAIVER - This is to certify that I/legal representative have been informed of the ABI Waiver Program. Consideration for the ABI Waiver Program as an alternative to NF or NF/ABI placement is requested ________; is not requested ________.  

_________________________________  
Signature  
_____ / _____ / ________  
Date

II. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.  

_________________________________  
Signature  
_____ / _____ / ________  
Date
III. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that I/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Community Based Services.

_________________________________________ / ____ / ____
Signature Date

IV. RECIPIENT INFORMATION

Medicaid Recipient’s Name: ____________________________________________
Address of Recipient: ___________________________________________________

Phone: (____) _________________________________________________________
Medicaid Number: ______________________________________________________
Responsible Party/Legal Representative: _________________________________
Address: __________________________________________________________________

Phone: (____) _________________________________________________________

Signature and Title of Person Assisting with Completion of Form:
_________________________________________ _____________________________
Signature Title

Agency/Facility:

________________________________________

Address:

________________________________________

________________________________________