



DIVISION OF POLICY AND OPERATIONS

I. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, INDIVIDUALS WITH INTELLECTUAL 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. SCL - This is to certify that I/legal representative have been informed of the home and community based waiver program for people with intellectual/developmental disabilities. Consideration for the waiver program as an alternative to ICF/IID **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:
