

**LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED PROGRAM  
CERTIFICATION FORM**

**I. ESTATE RECOVERY**

Pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1993, states are required to recover from an individual's estate the amount of Medicaid benefits paid on the individual's behalf during a period of institutionalization or during a period when an individual is receiving community based services as an alternative to institutionalization.

In compliance with Section 1917 (b) of the Social Security Act, estate recovery will apply to nursing facility long term care services (NF, NF/BI, ICF/MR/DD), home and community based services that are an alternative to long term care facility services and related hospital and prescription drug services.

Recovery will only be made from an estate if there is no surviving spouse, or children under age 21, or children of any age who are blind or disabled.

I certify that I have read and understand the above information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**II. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND  
DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL  
DISABILITIES, MODEL WAIVER II, 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. BRAIN INJURY (BI) WAIVER - This is to certify that I/legal representative have been informed of the BI Waiver Program. Consideration for the BI Waiver Program as an alternative to NF or NF/BI placement is requested \_\_\_\_\_; is not requested \_\_\_\_\_.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**III. 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

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**IV. 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

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**V. RECIPIENT INFORMATION**

Medicaid Recipient's Name: \_\_\_\_\_

Address of Recipient: \_\_\_\_\_

Phone: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_

Responsible Party/Legal Representative: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

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Signature and Title of Person Assisting with Completion of Form:

\_\_\_\_\_  
Agency/Facility: \_\_\_\_\_

Address: \_\_\_\_\_