



**DIVISION OF POLICY AND OPERATIONS**

**I. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH ITELLECTUAL 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/IDD **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: (\_\_\_\_\_) \_\_\_\_\_

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**Signature and Title of Person Assisting with Completion of Form:**

\_\_\_\_\_  
**Signature** **Title**

**Agency/Facility:**

\_\_\_\_\_

**Address:**

\_\_\_\_\_

\_\_\_\_\_