BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES SIGNATURE PAGE

INDIVIDUAL NAME (Print): _____ RID Number: _____

Bureau of Developmental Disabilities Services (BDDS) Freedom of Choice

Section 1902(a) (23) of the Social Security Act says that all Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. As a Medicaid beneficiary, you have the right to choose how you will receive services.

☐ CIH OR FS WAIVER SERVICES

I choose to be in the ICF/ID Medicaid Waiver program and receive Supported Living Services from a provider I will choose from a list of approved providers given to me by BDDS or my case manager. I am choosing:

- ☐ Waiver services in my family's home
- ☐ Waiver services in a Structured Family Caregiving setting
- ☐ Waiver services in a Supported Living home

☐ NON-WAIVER SERVICES

I choose to be in the Medicaid program and receive ICF/ID non-waiver services from a provider I choose from a list of BDDS approved providers. The service I am choosing is:

- ☐ Supported Group Living (group home)
- ☐ Nursing facility
- ☐ Large Private ICF/MR

☐ I DO NOT CHOOSE ICF/ID MEDICAID SERVICES

I DO NOT choose to be in the Medicaid program and receive waiver or non-waiver ICF/ID services. I understand that I can ask BDDS to assist me by conducting a transition meeting where we will discuss community resources that may be available to assist me. I am choosing:

- ☐ I want BDDS to have a transition meeting with me before I leave services.
- ☐ I do not want BDDS to have a transition meeting with me and I want to end my Medicaid funded ICF/ID services immediately.

Service Plan

CHOICE OF PROVIDERS

If the recipient chooses to receive waiver services, they have the right to select any approved waiver services provider(s).

☐ I have been informed of my right to choose any certified waiver provider when selecting waiver service providers.

Service Plan Serial Number:		Number of Days Covered by Plan:	
Service Plan Beginning Date:		Service Plan Ending Date:	

Receipt of DDRS Waiver Manual

☐ I have received a copy of, or link to, the DDRS Waiver Manual.

PCISP Statement of Agreement (Individual/Guardian)

☐ I have been involved in the development of my Person-Centered Individualized Support Plan and I agree with this plan. I know I can appeal to the Division of Developmental Disabilities and Rehabilitative Services (DDRS) if I disagree with how this plan is put into action.

All team members will sign on the following page to signify their agreement with this Person-Centered Individualized Support Plan.

PCISP Statement of Agreement (Individualized Support Team)

☐ Team members responsible for implementation signify their agreement with this Person-Centered Individualized Support Plan.

Meeting Date: PCISP Effective Date:

PCISP Serial Number:

Parent *(If not signing as guardian below):*

Signature	Date	Printed Name
Advocate:		
Signature	Date	Printed Name
Primary Day Service:		
Signature	Date	Printed Name
Residential Service:		
Signature	Date	Printed Name
Behavior Service:		
Signature	Date	Printed Name
Case Manager:		
Signature	Date	Printed Name
Other Team Member:		
Signature	Date	Printed Name/Agency or Relationship
Other Team Member:		
Signature	Date	Printed Name/Agency or Relationship
Other Team Member:		
Signature	Date	Printed Name/Agency or Relationship

Signatures

Individual Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

BDDS Signature: _____ Date: _____

Case Manager Signature: _____ Date: _____