Freedom of Choice

Federal rules allow states to offer home and community-based services to individuals who:

Are found to require a level of institutional care (*hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)*) under the State plan;

a. Are members of a target group that is included in the applicable waiver or state plan;

b. Meet applicable Medicaid eligibility criteria; and

c. Require one or more waiver or state plan services in order to avoid services in an institution.

ODDS uses this form to verify an individual’s choice to receive HCBS in lieu of institutional care.
Individual’s information

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<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle initial</th>
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<tr>
<td>Prime number</td>
<td>County</td>
<td>Date of birth</td>
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Individual’s choice

By federal regulations, if you need services that may be available in an ICF/IID, nursing facility or hospital setting, we must inform you of other available services and give you a choice of home and community-based or institutional services (ICF/IID, nursing facility or hospital services).

1. I have reviewed my service needs and options with a case manager.
2. I have been informed of the choices available to me and have selected the following service:

☐ Facility for individuals with intellectual and developmental disabilities (ICF/IID)
☐ Home and community-based (waiver) ☐ Hospital
☐ Home and community-based (k-plan) ☐ Nursing facility

Signature of individual or legal representative  Date (mm - dd - yy)

☐ Self (adult applicant) ☐ Adult’s court-appointed guardian
☐ Minor’s parent or legal guardian ☐ ______________________

Signature of witness (when the customer is unable)  Date (mm - dd - yy)

Case manager’s certification

By signing below, I confirm that I have informed the individual of his or her right to choose an institutional setting or HCBS, and to accept or deny services. In addition, if the person is a child turning 18 and transitioning to the Adult Waiver, I confirm I have reviewed the LOC and agree it is accurate.

Signature  Date (mm - dd - yy)

Services coordinator  Personal agent  Other: ______

CDDP/Brokerage: ____________