

**Waiver 5 0208 Home and Community-Based Services  
Freedom of Choice and Consent Form effective 7/1/2018  
(To be completed annually or sooner if the member requests a change)**

Participant's Name: \_\_\_\_\_ AWACS #: \_\_\_\_\_ DOB: \_\_\_\_\_

The DDP Waiver 5 Freedom of Choice Form is used to ensure that all Developmental Disabilities Program waiver recipients understand their right to:

1. Choice of waiver services, including self direction
2. Choice of providers of DDP funded services
3. Choice of filing a fair hearing request
4. Choice between waiver services and Intermediate Care Facility for individuals with intellectual disabilities (ICF/IID)
5. Report suspected abuse, neglect, and exploitation to the appropriate reporting agency.

Please have the individual or guardian initial each item and sign and date at the bottom.

\_\_\_\_\_ I have been informed of services available through the Medicaid Home and Community-Based Services Waiver Program. The choice of service provider and choice of services are available to all persons in DDP-funded services subject to demonstration of assessed need.

\_\_\_\_\_ I have been informed of the conditions under which I may choose to self-direct my waiver services.

\_\_\_\_\_ I have been informed that if my assessed needs cannot be adequately and safely met in the community, I will not be offered DDP-funded services. I have also been informed that if while in DDP-funded services my condition deteriorates to the point that I cannot be maintained safely in the community, I could be subject to placement in a more restrictive setting such as an ICF/IID.

\_\_\_\_\_ I have been informed of services available in an ICF/IID facility.

\_\_\_\_\_ I have been informed that I have the right to request a Montana Department of Justice criminal background check at no personal cost to me for any person providing me with services not under contract with the DDP. I understand that employees of agencies under contract with the DDP are required to have background checks.

\_\_\_\_\_ I have been informed of the State of Montana fair hearing process if I am denied the service(s) of choice or the provider(s) of choice. I understand that I can request services continue at the same level during the hearing process. If the hearing decision is not in my favor I will be required to pay back any services received during this time.

\_\_\_\_\_ I have received a copy of the Waiver 5 addendum and it has been reviewed with me.

\_\_\_\_\_ I have been informed that if I suspect abuse, neglect, or exploitation, I can report the incident directly to the Adult Protective Services Hotline at 1-844-277-9300 if the victim is over age 18 or the Child Protective Services Hotline at 1-866-820-5437 if the victim is under the age of 18.

After reviewing my options and choices, I freely choose to (*check all that apply*):

- Receive services in the community via the HCBS DD Medicaid Waiver.
- Receive services from my existing provider(s). \_\_\_\_\_
- Receive services from a different provider (specify). \_\_\_\_\_
- Self direct allowable waiver services.
- Not receive DDP-funded waiver services at this time.

\_\_\_\_\_  
Individual/Guardian or Personal Representative \_\_\_\_\_ Date

\_\_\_\_\_  
Targeted CM \_\_\_\_\_ Date

\_\_\_\_\_  
Department Representative – for initial Waiver 5 \_\_\_\_\_ Date