

DDP CHILDREN'S AUTISM WAIVER
ACCEPTANCE FORM
EFFECTIVE 01/01/09

NAME OF CHILD _____ DATE OF BIRTH _____

NAME OF FAMILY MEMBER _____ RELATIONSHIP _____

The Developmental Disabilities Program (DDP) of the Department of Public Health & Human Services has selected your child for an opportunity to be accepted into the State of Montana's Medicaid funded home and community services waiver program for young children with autism. This is a program of intensive services for the benefit of a child with autism. Depending on the current age and status of the child the services may be available for a period of up to three years. The participation of family in the delivery of these services is vital to the success of the services.

This service program has a small number of openings and the opportunities to enter into the program are very limited. A waiting list is maintained which identifies those children who meet the appropriate criteria with the agreement of their families to be considered for acceptance into the program. There are many children on the waiting list. Due to the limited availability of service opportunities through the program and the large number of children waiting for the services of the program, the selection of children to whom an offer of service opportunities are to be offered is decided by computer generated random drawing. Your child has been selected through this process to receive an offer of an opportunity to enter the program. You have the choice of accepting or rejecting this opportunity on behalf of your child.

Children's Autism Waiver services are not entitled services. Parents of children in this waiver must agree to follow through with assigned objectives as outlined in the plan of care as a precondition of enrollment and continued participation in the waiver. If you accept this opportunity, in addition to participation in the delivery of the service, you will also be required to complete and return an annual family satisfaction survey that will be used to report to the DDP and to Medicaid your degree of satisfaction or dissatisfaction with these services.

Please indicate your decision by marking the choice you have made and then sign and date the signature line.

____ I/we accept this opportunity to enter the children's autism waiver program.

____ I/we do NOT accept this opportunity to enter the children's autism waiver program but request that the child remain on the waiting list for another possible opportunity until age 5.

____ I/we do NOT accept the opportunity to enter the children's autism waiver program and request that the child be removed immediately from the waiting list for the program.

Family Member signature

Date

OFFER MADE: The QIS must document here the opportunity (location, people present, and date).

FAX A COPY OF THIS COMPLETED FORM TO DDP CENTRAL OFFICE, CHILD AND FAMILY AUTISM WAIVER LIAISON AT (406)444-0230.