



# Home and Community-Based Services for Individuals with Developmental Disabilities

## CHOICE OF SUPPORTS AND SERVICES

I, \_\_\_\_\_, or my guardian, have been informed by \_\_\_\_\_  
Name of Individual Name of Staff

of \_\_\_\_\_ on \_\_\_\_\_ that I am eligible for Medicaid-funded  
PAS/ISSA Agency/Waiver Provider Date

services for individuals with a developmental disability.

I understand that I may choose community supports and services available through a Home and Community-Based Services waiver program or seek placement in an intermediate care facility for individuals with a developmental disability (ICF/DD). If I choose community supports and services, I understand that I will be required to grant reasonable access to my home for staff of the PAS/ISSA agency, staff of service provider agencies and State agency staff, as necessary in order to meet federal requirements concerning the health and welfare of individuals with developmental disabilities enrolled in the Medicaid waiver.

- I choose community supports and services through a Home and Community-Based Services waiver program, or
- I choose placement in an ICF/DD.

These options have been explained to me in enough detail so that I am able to make an informed choice. I also understand that I may change my choice of supports and services in the future.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness