State of Illinois
Department of Human Services
Division of Developmental Disabilities

Choice of Supports and Services - Ligas ICF/DD Outreach

I, _____ _____ - ____ - _____ , or my guardian, have been
Name of Individual SSN

informed of all my alternative choices for long term care services by _____
Staff Name

of The Council on Quality and Leadership (CQL) on _____ / ____ / _____ .
Date

I understand that I may choose community supports and services available through the Adult Home and Community-Based Services waiver program or continue to receive services in my current or a different intermediate care facility for individuals with a developmental disability (ICF/DD).

- ☐ I choose to become a Ligas Class Member and explore community supports and services through the Adult Home and Community-Based Services waiver program, or
- ☐ I choose to continue to receive services in my current ICF/DD, or
- ☐ I choose to explore services in another ICF/DD.

These options have been explained to me in enough detail so that I am able to make an informed choice. I understand that with the choice to explore other services, I will be referred to a Pre-Admission Screening Agency (PAS).

I confirm that all alternative choices for long term care services have been explained to the individual.

_____
Signature of Individual / Guardian

_____
Signature of CQL Staff

_____
Print Name

_____
Print Name

_____
Date

This form is for the sole use of the Ligas Outreach Contractor