State of Illinois
Department of Human Services

# HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

## CHOICE OF SUPPORTS AND SERVICES

I, _____, or my guardian, _____,
Name of Individual — Name of Guardian

have been informed by _____ of _____
Name of Staff — ISC Agency

on _____ that I am eligible for Medicaid-funded services for individuals with a developmental disability.
(Date)

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,
- ☐ I choose placement in an ICF/DD, or
- ☐ I choose an interim placement at an ICF/DD, while I continue to work with the ISC to identify a waiver placement. The DDD Region staff have been notified.

These options have been explained to me in enough detail so that I am able to make an informed choice. Before making my decision, I was given the opportunity to visit various residential settings. I also understand that I may change my choice of supports and services in the future.

_____
Individual's Printed Name

_____ _____
Individual Signature — Date

_____
Guardian's Printed Name

_____ _____
Guardian Signature — Date

_____
Witness' Printed Name

_____ _____
Witness Signature — Date