MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF SENIOR AND DISABILITY SERVICES

PARTICIPANT CHOICE STATEMENT

AGENCY, CDS, ADC, & SFCW

PARTICIPANT NAME	DCN	COUNTY NAME

The participant or authorized representative must initial next to each section indicating they have read and understood the information.

SERVICES AND PROVIDERS →	INITIAL HERE

1) I wish to receive Home and Community Based Services (HCBS): ☐ Agency ☐ Consumer-Directed ☐ Adult Day Care ☐ Structured Family Caregiving

2) I understand HCBS can only be approved by Division of Senior and Disability (DSDS) staff.

3) When choosing Consumer-Directed Services (CDS) for Personal Care Assistance, I understand I must be able to direct and oversee my own care. Independent Living Waiver (ILW) services may be directed by someone that I assign. However, I must continue to have the ability to direct my own care.

4) I understand I have the right to choose any willing and qualified HCBS provider. Names of all qualified providers were made available to me during the assessment and person centered care planning process. I also understand I have the right to change providers anytime I choose, and agree to let the provider know when I am not satisfied with the care I receive.

5) I have reviewed my rights and responsibilities and understand what I must do as a participant of HCBS.

6) I have been notified of the availability of and how to obtain a copy of DHSS' Notice of Privacy Practices.

PERSON CENTERED CARE PLAN →	INITIAL HERE

1) I understand my services must follow the current person centered care plan.

2) I agree to notify DSDS staff at **866-835-3505** if:

- o There is a change in my situation that may affect the person centered care plan;
- o I am not satisfied with the services or treatment I receive from the provider;
- o I want to change providers; or when
- o I have any unresolved issues with the provider.

3) I understand I can also call DSDS staff to request a change in my person centered care plan at any time throughout the year, including during my annual assessment.

4) I understand anyone I choose can be present during the person centered care plan process. All services I am eligible to receive have been discussed and reviewed with me. I have not experienced any undue pressure while creating the care plan. For example, I have not been pressured to choose a specific provider; or to accept a service that I did not choose.

5) I understand agency-model and CDS providers must use an Electronic Visit Verification (EVV) system as required by State and Federal law. Neither providers nor participants may opt out of using an EVV system for personal care services.

WELLNESS →	INITIAL HERE

1) I understand I can call the toll-free hotline at **1-800-392-0210** to report abuse, neglect or exploitation.

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PARTICIPANT NAME	DCN

COMMUNITY SERVICES AND SUPPORTS →	INITIAL HERE

1) List below any critical risks not addressed in the person centered care plan. List formal and/or informal supports which could provide additional assistance to keep me in the community. If there are no identified critical risks check here: ☐

Risks (ex: fall)	Support

2) List below any additional needs for support not addressed in the person centered care plan. List formal and/or informal supports which could provide additional assistance to keep me in the community. If there are no identified additional needs check here: ☐

Needs (ex: utilities)	Support

3) I understand I have the right to refuse a referral to a community resource or support and accept the risks related in not accepting the resource/support.

4) I have the right to receive Medicaid HCBS in settings that are integrated in and support full access to the greater community. This includes opportunities to:

- o seek employment and work in competitive and integrated settings;
- o engage in community life;
- o control personal resources; and
- o receive services in the community to the same degree as individuals who do not receive HCBS.

5) I agree to notify DSDS staff at **866-835-3505** if I have concerns with my services.

6) I understand I must meet nursing home level of care for the HCBS service I have chosen and that I have the right to enter a nursing facility if I choose.

By signing below, the Assessor agrees the information used to determine eligibility and document need for services has been obtained from the participant or his/her authorized representative and is believed to be true, accurate, and complete. The Assessor attests that without authorized HCBS, the participant would require nursing facility placement.

ASSESSOR SIGNATURE	DATE

ASSESSOR NAME (PRINTED)	EMPLOYED BY

PARTICIPANT SIGNATURE/RESPONSIBLE PERSON FOR THE PARTICIPANT SIGNATURE & RELATIONSHIP	DATE