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

PARTICIPANT CHOICE STATEMENT

RESIDENTIAL CARE FACILITY/ASSISTED LIVING FACILITY

PARTICIPANT NAME	DCN	COUNTY NAME

The participant 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) at the Residential Care/Assisted Living Facility (RCF/ALF).
2) I understand the RCF/ALF in which I chose to reside will be the provider for HCBS identified in the person centered care plan.
3) I have reviewed my rights and responsibilities and understand what I must do as a participant of HCBS.
4) 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 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 that I receive from the provider;
   - o I want to change providers;
   - o I have any unresolved issues with the provider; or
   - o I have concerns with my services.
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 person centered care plan. For example, I have not been pressured to accept a care plan that does not fit my needs.

WELLNESS →	INITIAL HERE

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

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