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

PARTICIPANT CHOICE STATEMENT

Home and Community Based Services

PARTICIPANT NAME	MEDICAID NUMBER (DCN)	COUNTY NAME

1) I agree all Home and Community Based Services (HCBS) I am eligible to receive have been discussed and reviewed with me.
2) I understand I have the right to choose any willing and qualified HCBS provider and that a list of all qualified providers is available to choose from.
3) I understand I have the right to choose who is present during the care planning process.
4) I agree to notify DSDS staff at **866-835-3505** if:
    - There is a change in my situation that may affect my care plan;
    - I am not satisfied with the services or treatment I receive from the provider;
    - I want to change providers;
    - I have any unresolved issues with the provider; or when
    - I have concerns with my services
5) I understand I can also call DSDS staff at **866-835-3505** to request a change to my care plan at any time throughout the year.
6) I have reviewed my rights and responsibilities and understand what I must do as a participant of HCBS.
7) I have been notified of the availability of and how to obtain a copy of DHSS' Notice of Privacy Practices.
8) I understand I can call the toll-free hotline at **1-800-392-0210** to report abuse, neglect, exploitation and other critical incidents.
9) 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.
10) 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:
    - seek employment and work in competitive and integrated settings;
    - engage in community life;
    - control personal resources; and
    - receive services in the community to the same degree as individuals who do not receive HCBS.
11) 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 home 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.

ASSESSOR SIGNATURE	DATE

ASSESSOR NAME (PRINTED)	EMPLOYED BY

By signing below, I the participant or legally responsible person, agree with the developed care plan and items discussed on this form. I also attest that the information concerning health and level of need for assistance is truthful and accurate to the best of my knowledge. I understand knowingly providing inaccurate information is punishable crime. "Any person or corporation who obtains or attempts to obtain, or aids or abets any other person to obtain, by means of a willfully false statement or representation, or by willful concealment or failure to report any fact or event required to be reported by any law, regulation, or rule of this state or the United States, or by impersonation, collusion, or other fraudulent device, any public assistance benefits, programs, and services, shall be guilty of the crime of stealing as defined by section 570.030 and shall be punished as provided in section 570.030." (Section 205.967.2, RSMo).

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