



**MISSOURI DEPARTMENT OF HEALTH
BUREAU OF SPECIAL HEALTH CARE NEEDS
CLIENT CHOICE STATEMENT**

Client Name:	DCN:
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I certify that all possible choices under the Physical Disabilities Waiver/State Plan Personal Care Program have been explained to me. I was given a choice of waiver services or an Intermediate Care Facility for the Mentally Retarded or Developmentally Disabled (ICF/MR). I choose to receive waiver services.

I have discussed the results of the assessment with my service coordinator and have participated in the development of a plan for services.

I understand if my services are reduced, closed or denied, I will be advised in writing. I will have the right to appeal the decision as specified in 42 Code of Federal Regulations 431.200 - .250. A hearing may be requested within ninety (90) days of the date of the letter. To request a hearing I should contact Recipient Services by letter, telephone or in person. A hearing will then be scheduled for me and I will be notified of the time of the hearing. If a hearing is requested within 10 days of the date of the letter, services will continue pending the hearing decision.

The address is: Missouri Division of Medical Services
Recipient Services
615 Howerton Court
P.O. Box 6500
Jefferson City, MO 65102

The telephone number is: 1-800-392-2161

I have received information regarding available provider agencies and understand I can choose which agency is to provide my services.

Client/Legal Representative Signature:	Date:
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