MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SPECIAL HEALTH CARE NEEDS
MEDICALLY FRAGILE ADULT WAIVER

CLIENT CHOICE STATEMENT

PARTICIPANT NAME	DCN	SSN	DOB

I certify that all possible services under the Medically Fragile Adult 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 Individuals with Intellectual Disabilities (ICF/IID). I choose to receive Medically Fragile Adult Waiver services. I acknowledge that I will not be able to participate in other waiver programs in addition to the Medically Fragile Adult Waiver.

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 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: MO HealthNet Division
Recipient Services
615 Howerton Court
PO 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.

Authorization To Release Information

I authorize Department of Health and Senior Services, Special Health Services (SHS) to release or obtain information to or from any agencies which are participating in the treatment and care plan for the above named participant.
I consent to the release of medical information and supporting documents to the agencies that administer relevant or applicable programs for establishing and verifying eligibility and for performing evaluations. I understand that the agencies that administer such programs will maintain confidentiality of this information according to the applicable laws.
I have been informed that SHS provides care on a nondiscriminatory basis as required by Title VI of the Civil Rights Act of 1964.

PARTICIPANT/LEGAL REPRESENTATIVE SIGNATURE	DATE