Section II
Freedom of Choice:
(To be completed by Person, Parent/Guardian, and Service Coordinator)

I. Freedom of Choice

The signature on this form attests that the person or the parent/guardian/authorized representative have received an explanation of the District of Columbia's Home and Community Based Services (HCBS) Waiver for persons' with Intellectual and other Developmental Disabilities (I/DD) and have been presented with a list of enrolled HCBS providers.

Choice of Provider (Please Check which Applies)

A. _____At this time, I choose to receive community-based supports and services and understand that I have a choice of enrolled Providers.
B. _____At this time, I do not choose to receive community-based supports and services and I understand that I have a choice to select waiver services at another time
C. _____At this time, I choose to receive institutional services (ICF/IDD) and prefer services to be provided in an institutional setting.

Selection of HCBS Waiver (check one)

I understand that enrollment on a Medicaid Home & Community Based Services (HCBS) Waiver is strictly voluntary. I also understand that if enrolled I will be receiving Waiver services instead of services in an Intermediate Care Facility for individuals with Intellectual and Developmental Disabilities.

- ❑ I have chosen HCBS Waiver Services
- ❑ I have not chosen HCBS Waiver Services

II. Applicant's Responsibilities if HCBS Waiver is selected *(Review with person or the parent/guardian/authorized representative and check all to attest to review and understanding)*

- ❑ I understand the HCBS Waiver must keep the cost of my services below a certain dollar amount for me to be on the Waiver.
- ❑ I understand the HCBS Waiver will deliver services according to my Individual Service Plan (ISP). I will cooperate in reassessment when my ISP is about to expire.
- ❑ I understand that my ISP will be monitored and reviewed by my DDA Service Coordinator and that I can contact my Service Coordinator at any time I have questions about my ISP or the services that I receive
- ❑ I understand that I have the right to choose the provider for each of my HCBS Waiver services.

III. Notice of Fair Hearing

This attests that the with person or the parent/guardian/authorized representative have received an explanation the persons rights under 42 CFR Part 431, subpart E to make an administrative appeal, rights for a fair hearing under D.C. Law 4-10l, Title X, and D.C. Code 1-1509

- ❑ I understand that if I am not allowed to make my own a decision about whether to use ICF/IDD or Waiver Services I can request a Fair Hearing and the DDA Service Coordinator will assist with that process.
  Comment:_____
- ❑ I understand that if I am not allowed to make my own a decision about which service provider I select I can request a Fair Hearing and the DDA Service Coordinator will assist with that process.
  Comment: _____

IV. Freedom of Choice Signatures	
Person	**Date:**
Guardian/ Authorized representative:	**Date**
Service Coordinator Signature:	**Date**