



Office for People With Developmental Disabilities

DOCUMENTATION OF CHOICES

A) *SELECTION OF HCBS WAIVER:*

I _____ (applicant), have been informed that I am eligible for care provided through either an Intermediate Care Facility (ICF), or Home and Community Based Services (HCBS). My choice is indicated below.

_____ I have chosen HCBS _____ I have not chosen HCBS

B) *SELECTION OF CARE COORDINATION ORGANIZATION (CCO):*

CCO: _____

Contact Name: _____

Address: _____

Phone: _____

C) *ASSURANCE OF INFORMED CHOICE:*

_____ (CCO Representative), has informed me of the currently available options regarding care management, care coordination services.

Applicant has the right to pursue changes in choice at any time.

D) *SIGNATURES:*

(Applicant Signature/Date)

(Care Manager Signature/Date)

(Advocate Signature/Date)

(OPWDD Representative Signature/Date)