Informed Choice Required Signature Document

Person's Name:	Date:

Note: Complete the Informed Choice Required Signature Document by obtaining signatures and initials. Retain hard copy document with signatures and initials for later Department of Medicaid (DOM) review (if requested).

PERSON'S CHOICE			
Option	**Presented as Option, based on Screen?**		**Person's Choice (Initial)**
	Yes	**No**	
Nursing Facility Placement	☐	☐	
Assisted Living Waiver	☐	☐	
Elderly & Disabled Waiver	☐	☐	
Independent Living Waiver	☐	☐	
TBI/SCI Waiver	☐	☐	
Other (specify):	☐	☐	

Screener:

I have informed the person and/or the person's legal representative of the available DOM-covered long term care options, including alternatives to Nursing Facility placement, based on the results of the PAS and the person's desired services.

Signature:	Date:	Name:	☐ RN ☐ LSW

Person:

I hereby acknowledge my participation in this screening process, agree that I have had long term care program options explained to me and have indicated my choice by initialing in the appropriate box above. I have also been informed that the Medicaid program has financial eligibility requirements not addressed as part of this screen. I authorize the agency or attending physician to provide the DOM with information necessary to meet the federal requirements for review and/or assist me in seeking long term care services.

Signature of Person/Legal Representative:	Date:
Signature of Witness:	Date: