

Choice Form
Home and Community Based Services
Physically Disabled
For Consumers Turning Age 65

Name

Identification Number

I am currently a consumer receiving services under the Home and Community Based Services for the Physically Disabled (HCBS/PD) waiver. I will reach the age of 65 while receiving these services. The results of the assessment of my medical/personal needs indicate that I continue to qualify for long term care services, and that services essential to my health and welfare can be provided to me in my home or community-based setting within the program cost limits. I have been informed that I am functionally eligible to receive services and may opt to remain in the community and receive these services either under the HCBS/PD waiver or under the Home and Community Based Services for the Frail Elderly (HCBS/FE) waiver. My signature below indicates I have been informed of this choice and have read my rights and responsibilities on the reverse of this form.

READ REVERSE SIDE OF THIS FORM BEFORE PROCEEDING.

My choice is to: (check one)

- _____ Enter a Nursing Facility
- _____ Receive services under the HCBS/PD waiver
- _____ Receive services under the HCBS/FE waiver
- _____ Refuse the Recommended Services

If I choose to receive Home and Community Based Services, under either the HCBS/PD or HCBS/FE waiver, I understand I have the option to self-direct my attendant services. It is my choice: (check one)

- _____ To self-direct my attendant services
- _____ Not to self-direct my attendant services

SIGNATURES:

DATE:

Consumer

Guardian or Authorized Representative

IL Counselor
