

## HCBS/TBI Waiver Consumer Choice Form

\_\_\_\_\_  
Consumer Name

\_\_\_\_\_  
SSN

The assessment results indicate that my medical/personal needs qualify me for traumatic brain injury (TBI) services and that services essential to my health and welfare can be provided to me in my home or other community-based setting within the cost limitations of the program. I have been informed that I am eligible to receive services and have the option to remain in the community and receive the services as designated on the Plan of Care.

*It is my choice to:*

\_\_\_\_\_ Enter a TBI Rehabilitation Facility

\_\_\_\_\_ Receive Home & Community Based Services (HCBS) under the TBI Waiver

\_\_\_\_\_ Enter a TBI Rehabilitation Facility and then receive HCBS services when appropriate

\_\_\_\_\_ Decline services

*If I choose to receive HCBS, I understand that I have the option to self-direct my attendant services.*

*It is my choice:*

\_\_\_\_\_ To self-direct my attendant services

\_\_\_\_\_ Not to self-direct my attendant services

- I understand, by choosing HCBS, that I am not responsible for payment of Medicaid co-pays.
- I have been given my choice of providers and payroll agents.
- I have been advised of my option to seek a KBI background check on the individuals I hire.
- I understand I have certain rights and responsibilities as listed on the back of this form.
- I understand I am responsible for my client obligation if there is one.

My signature verifies that I have read, or have had read to me, my rights and responsibilities and have made the choices as indicated above. I have also participated in the design of my Plan of Care.

\_\_\_\_\_  
Consumer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
TBI-TCM Signature

\_\_\_\_\_  
Date