

**Choice Form
Home and Community Based Services
Physically Disabled**

Name

Identification Number

The results of the assessment of my medical/personal needs indicate that I 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 the services as designated in the Plan of Care. 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 Home and Community-Based Services as Indicated on the Attached Plan of Care.

_____ Refuse the Recommended Services

If I choose to receive Home and Community Based Services, 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

TCM
