Informed Choice Required Signature Document

Person 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 DOM review (if requested)

3. Person 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):			
Comment:			

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	Printed Name	Credentials

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 also have 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.

Signed: _____ _____
Person/Legal Representative Date

Signed: _____ _____
Witness Date