

**MEDICAID WAIVER CONSUMER CHOICE
OF SERVICES/LIVING ARRANGEMENT STATEMENT**

DS 2200 (Rev. 2/2000) (Electronic Version)

The consumer, parent/legal guardian, or legal representative, or involved other person has been informed of the feasible alternative of services available. The consumer has been offered a choice of receiving such services in a community care residential facility, in an in-home living arrangement, or in a long-term health facility (ICF/DD, ICF/DD-H, or ICF/DD-N).

Consumer Identification Information/Date of Choice

Consumer's Name	Date of Choice (date form completed)
UCI	DOB

Choice of Services/Living Arrangement**I. MINORS**

The consumer is a minor. The choice of living arrangement has been made by the ☐ parent, ☐ legal guardian, or ☐ legal representative as indicated in Section III below:



Signature

Date

II. ADULTS

a. The consumer is an adult and has chosen the living arrangement as indicated in Section III below:



Client's signature/mark ("X")

Date



Witness' signature

Date

The consumer is an adult but is unable to make such choice. The choice of living arrangement has been made by:

- b. ☐ The consumer's legal representative; or, if the client has no legal representative
- c. ☐ The consumer's parents, relatives or other persons actively involved in the development of the consumer's plan of care;



Signature

Date

III. SERVICES/LIVING ARRANGEMENT

- A. ☐ A long-term health facility (ICF/DD, ICF/DD-H, or ICF/DD-N)
- B. ☐ A community care residential facility, or
- C. ☐ Consumer's choice of living arrangement other than above (please specify): _____

IV. DISENROLLMENT FROM MEDICAID WAIVER

- A. ☐ I choose/my legal guardian/representative chooses to terminate my Medicaid Waiver participation. Since this is my choice, I will not be requesting a fair hearing.



Signature

Date

V. COMMENTS:

INSTRUCTIONS FOR MEDICAID WAIVER CONSUMER CHOICE OF SERVICES/LIVING ARRANGEMENT STATEMENT

Under the terms of the Title XIX Medicaid Waiver Program, each consumer must be informed of any feasible alternative services under the Waiver and be given a choice of receiving those services in a community care residential facility, in-home living arrangement, or long-term health facility. If those services are not offered or available, the consumer or his or her representative must be apprised of his/her right to a fair hearing.

The DS 2200 Medicaid Waiver Consumer Choice of Services/Living Arrangement is to be completed as follows:

Consumer Identification Information/Date of Choice

Enter the consumer's first and last name.

Enter the date the choice is offered which should be concurrent with the date the consumer is either initially enrolled in the Medicaid Waiver program or the date of reenrollment in the Medicaid Waiver program after a period of ineligibility greater than 120 days.

Enter the consumer's unique identifier (UCI).

Enter the consumer's date of birth.

Choice of Services/Living Arrangement

The following persons are responsible for making the Medicaid Waiver choice of services/living arrangement determination. The signature of such persons must be consistent with the signatures for other consent forms, release of information forms, etc. contained in the consumer's record.

Minors

The parent/legal guardian/legal representative must make the choice by marking the box indicating who is making the choice, signing, and dating the form. Box A, B, or C in Section III, Services/Living Arrangement must be marked.

Adults

- a. The consumer indicates his/her choice by signing his/her name or making his/her mark. The consumer's mark must be witnessed. A representative of the interdisciplinary (ID) team may be a witness. The choice form must be dated. Box A, B, or C in Section III, Services/Living Arrangement must be marked.

OR

- b. The consumer has a legal representative. The legal representative must make the choice by marking the box indicating who is making the choice, signing and dating the form. Box A, B, or C in Section III, Services/Living Arrangement must be marked.

OR

The ID Team

- c. Parents, relatives, or others involved in the development of the consumer's plan of care who represent the ID team for those consumers who are not able to indicate their choice and do not have a legal representative must make the choice by marking the box indicating who is making the choice, signing, and dating the form. Box A, B, or C in Section III, Services/Living Arrangement must be marked.

Consumer Choice to Disenroll from the HCBS Waiver Program

Should an HCBS consumer or his/her parent, legal guardian, representative wish to voluntarily terminate enrollment, the consumer or his/her parent, legal guardian, representative should mark the box and sign and date the form to document his/her/their choice.

Comments

Use this section to provide any clarification or explanation with either the choice of services/living arrangement, the signatures, or dates provided.

NOTE: In those instances when services or choice of living arrangement (community or health facility) cannot be provided, the consumer/parent/legal guardian or legal representative/other involved person must be apprised that they are entitled to a fair hearing.