

DEPARTMENT OF HUMAN SERVICES
HOME AND COMMUNITY-BASED CARE WAIVER
NOTIFICATION OF RECIPIENT CHOICE

RECIPIENT NAME :
ADDRESS :
CASE NUMBER :

Recipient Notification

I understand that I have been assessed and found to require the services provided in a Skilled Nursing or an Intermediate Care Facility. I have been offered a choice between in-home community-based care and in-patient care in a Skilled Nursing or an Intermediate Care Facility. I have chosen:

_____ Placement in a Skilled Nursing or Intermediate Care Facility

_____ In-Home Community-Based Care which may include Home Health Services, Homemaker Services, Adult Day Care, and other Medical Assistance program covered services

Signature of Recipient or Representative Date