

**COMMONWEALTH OF PENNSYLVANIA
OFFICE OF LONG-TERM LIVING
Bureau of Participant Operations**

FREEDOM OF CHOICE FORM

Name (Last, First, Middle): _____

Address: _____

- I have been informed that I may be eligible for home and community-based services (HCBS).
- I know that enrollment in a home and community-based program is up to me.
- I have been informed what services I may be able to get and my rights and responsibilities under each service.
- Based on the information that has been presented to me, I want to [*check one*]:
 1. Receive HCBS such as Waiver or the LIFE Program where available.
 2. a Receive services in a nursing facility
b Receive services in an Intermediate Care Facility/Other Related Conditions (ICF/ORC)
 3. Receive no services
- If I choose to receive HCBS, I know that I have the right to pick the agency that will provide each of my HCBS services from among the enrolled Medicaid HCBS providers in my area.

- Maintain original at Enrolling Agency/AAA
- Copy to the consumer and representative (if applicable)
- Copy to selected Service Coordination Agency

- I have been given my choice of Service Coordination agencies by the Enrolling Agency.
- I know that I may change my Service Coordination agency at any time.
- I know that the Service Coordination agency will review the list of available HCBS providers with me.

I have chosen the following agency as my Service Coordination agency:

Service Coordination agency name

For all applicants to complete:

This form was thoroughly discussed with _____
Participant/Representative

by _____ by means of _____
Service Coordinator/IEB/AAA (ex. Translator, American Sign Language, written, oral)

Applicant/Representative's Signature Date

Service Coordinator/IEB/AAA Signature Date

Form Distribution

- Maintain original at Enrolling Agency/AAA
- Copy to the consumer and representative (if applicable)
- Copy to selected Service Coordination Agency