

**COMMONWEALTH OF PENNSYLVANIA
OFFICE OF LONG-TERM LIVING
FREEDOM OF CHOICE FORM**

Participant Name (Last, First, Middle): _____

Participant ID Number: _____

- I have been informed that I may be eligible for Home and Community-Based Services (HCBS).
- I have been informed that enrollment in a HCBS program is my choice.
- I have been informed what services I may receive and my rights and responsibilities under each service.
- Based on the information that has been presented to me, I choose to [*check one*]:
 1. Receive HCBS such as Waiver services or the Living Independence for the Elderly (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 have the right to choose the agency that will provide each service from among the enrolled Medicaid HCBS providers in my area.
- I have been provided a choice of Service Coordination Entities by the Enrolling Agency.
- I may change my Service Coordination Entity at any time.
- The Service Coordination Entity reviewed the list of available HCBS providers with me.

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

Service Coordination Entity name

This form was thoroughly discussed with: _____
Participant/Representative

Form Distribution

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

Freedom of Choice Form
February 2016

By: _____ by means of: _____
Service Coordination Agency, Translator, Sign Language,
Independent Enrollment Broker, or Written, Oral, Other (please specify)
Area Agency on Aging

Participant/Representative (Signature) Date

Service Coordination Agency, (Signature) Date
Independent Enrollment Broker, or
Area Agency on Aging

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