

**CERTIFICATION OF CHOICE
INFANTS, TODDLERS & FAMILIES MEDICAID WAIVER**

1. Confirmation That Information About Choice is Provided

I, _____, have been informed:
FAMILY OR LEGAL REPRESENTATIVE OF INFANT OR TODDLER

- a. that my child has been determined likely to qualify for waiver funding for some or all of the services authorized in the child's individualized family services plan (IFSP).
- b. about feasible home and community based service alternatives, including services funded under the Medicaid Waiver, EPSDT, the EI-MA let schedule and other state/county funded early intervention.
- c. about my right to indicate a choice for home and community services funded under the Medicaid waiver or ICF/MR/ORC
- d. about my right to a Medicaid fair bearing and appeal 1.

In designating my choice for services:

- a. I acknowledge that home and community service alternatives have been explained to my satisfaction. including waiver funding for IFSP services
- b. I understand that waiver funded service(s) will only be available to the extent that they are needed based on my child's IFSP.

I understand that my child will receive the services in the IFSP, regardless of whether I choose to participate in the waiver.

- d. I understand that some of the services on the IFSP can be funded through the waiver, and that other services can be funded through other funding streams. but that in any case, my child must receive all the early intervention services authorized on the IFSP.

II. Designation of service Choice

My service choice is: (check one only)

- I choose to participate in the waiver.
- I choose ICF/MR/ORC for my child.

III. Participant Information and Signatures

INFANT/TODDLER NAME:	ACCESS NUMBER:
ADDRESS:	
	TELEPHONE NUMBER:
PARENT, FAMILY OR LEGAL REPRESENTATIVE NAME:	
SIGNATURE:	DATE:
ADDRESS:	
	TELEPHONE NUMBER:
COUNTY MH/MR DESIGNEE NAME:	
SIGNATURE:	DATE:
ADDRESS:	
TITLE:	TELEPHONE NUMBER: