

## HOME AND COMMUNITY-BASED SERVICE PREFERENCE FORM

### I. Confirmation of Understanding

This is to certify that I, \_\_\_\_\_ or my legal representative  
(NAME OF INDIVIDUAL)  
 \_\_\_\_\_ have been informed of the following:  
(NAME OF LEGAL REPRESENTATIVE)

- a. that I am likely to require the level of care provided in an intermediate care facility for people with mental retardation, or ICFIMR.
- b. about feasible home and community-based service alternatives to services provided in an ICFIMR.
- c. about my right to indicate a preference for home and community-based services funded under the waiver as an alternative to services provided in an ICFIMR and about my rights to a fair hearing before the Department of Public Welfare, Bureau of Hearings and Appeals.

In declaring my preference for home and community-based services funded under the waiver or ICFIMR, I understand the following:

- a. that I must meet Department of Public Welfare eligibility standards to receive services funded by the waiver.
- b. that a fair hearing and appeal will not be granted if I am appealing changes caused solely by state or federal law, regulation or policy requiring a change in the type of services available.

### II. Designation of **S**ervice Preference

My service preference is: (initials or mark of individual, legal **r**epresentative, or QMRP beside one option)

home and community-based services funded under the waiver

services in an ICF/MR

### III. Participant Information and Signatures

A. Individual. (This section must be completed for the individual needing services).

INDIVIDUAL NAME:	
ACCESS NUMBER:	
SIGNATURE:	
ADDRESS:	TELEPHONE NUMBER:
	DATE:

B. Legal Representative. (This section must be completed when the individual's legal representative signifies the preference for waiver or ICFIMR services on the individual's behalf. This section applies only to individuals who are age 18 and younger).

#### Legal Representative

NAME:	
SIGNATURE:	
ADDRESS:	
	TELEPHONE NUMBER:
	DATE:

C. County MHIMR Program Designee (This section must be completed by the County MH/MR Program who offers the individual or legal representative the preference for waiver or ICFIMR services).

COUNTY DESIGNEE NAME:	
TITLE:	
AGENCY ADDRESS:	
	TELEPHONE NUMBER:
SIGNATURE:	DATE:

D. Independent Qualified Mental Retardation Professional (This section must be completed by the independent qualified mental retardation professional who serves to document the individual's preference for waiver or ICFIMR services).

NAME:	
AGENCY:	
ADDRESS:	
	TELEPHONE NUMBER:
SIGNATURE:	DATE: