



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

**Freedom of Choice Form
Home and Community Based Services Waivers**

_____ I freely choose to accept home and community-based services. I understand that there are alternative services for which I am eligible, including services in an institution. The Waiver will offer me home and community based services as an alternative to institutional services.

It has been explained to me that should I qualify for the program, I will have the right to choose my waiver services and providers. Also, I will participate fully as a co-planner in developing my plan of service. I understand and considered my options, which have been explained to me. It is my wish to receive home and community-based services under the Waiver as an alternative to receiving services in an institution.

I further understand that in order to continue to receive home and community-based services, I must meet all of the eligibility criteria of the Maryland Medical Assistance Program and the Waiver. I also understand that I can change my mind about my choice of options at any time simply by contacting my case manager.

_____ I choose to receive services in an institution.

_____ I choose to neither of these service options.

My signature below indicates that I have been informed of the various options available for my choice and that any questions that I may have about my options have been answered.

Printed Name: _____

Signature: _____ **Date:** _____

Client or Authorized Representative