MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF SENIOR AND DISABILITY SERVICES

HOME AND COMMUNITY BASED SERVICES CARE PLAN AND PARTICIPANT CHOICE STATEMENT

PARTICIPANT NAME	DCN	COUNTY NAME

The participant must initial next to each section indicating they have read and understood the information.

	I understand that I have the right to enter/remain in a nursing facility or utilize Home and Community Based Services (HCBS); (Waiver and/or State Plan).
	I wish to receive HCBS through the: ☐ agency option ☐ consumer-directed option.
	When choosing Consumer-Directed Model (CDS) for Personal Care Assistance, I understand that I must be able to direct and oversee my own care. Independent Living Waiver (ILW) services may be directed by someone that I appoint – however, have the ability to appoint someone and I must continue to have the capacity to direct my care. ILW services can ONLY be approved by the Division of Senior and Disability (DSDS) staff.
	I understand I have the right to choose any willing and qualified HCBS provider (Waiver and/or State Plan). Names of all qualified providers were made available to me during the assessment and care planning process.
	I understand I have the right to change providers anytime I choose.
	I, and/or the individual(s) of my choosing, have discussed the results of the assessment with the Assessor and have participated in the development of a person centered care plan for Home and Community Based Services.
	I understand my services must be provided in accordance with a current plan of care.
	I agree to notify the provider when I am not satisfied with the care I receive.
	I agree to notify DSDS staff at _____ (Regional Evaluation Team) any time there is a change in my circumstances that may affect the person centered care plan, when I am not satisfied with the services or treatment I receive from the provider, I want to change providers, or when I have any unresolved issues with the provider.
	I understand that I can request DSDS staff at _____ (Regional Evaluation Team) to assist in the development of the person centered care plan at any time throughout the year; including during my annual assessment.
	I have not experienced any undue influence on the care planning process (i.e., exercising free choice of providers, controlling the content of the care plan – regarding the type of services, frequency, and duration). In addition, all services that I may be eligible to receive have been discussed/reviewed with me.
	I have reviewed my rights and responsibilities on page two of this form and understand what I must do as a participant of HCBS.
	I understand all providers of HCBS utilize Electronic Visit Verification systems as required by State statute. This does not include Adult Day Care, RCF, or ALF providers.

IDENTIFIED supports and services/needs (other than the authorization of DSDS HCBS) as a means to live successfully in the community and therefore avoid nursing facility placement.

Below are identified critical risks and needs for supports beyond the authorized HCBS care plan identified and discussed during the comprehensive assessment. Identify formal or informal supports who is, or will be, providing the assistance, or who need to be contacted for follow-up.

CRITICAL RISKS	REFERRED TO	NEEDS	PROVIDED BY / REFERRED TO

	I understand that any risks identified during the assessment process were discussed with me, and I further understand the risks associated in not accepting any HCBS or referral to a community resource.
	I understand I can call the toll-free hotline at **1-800-392-0210** to report abuse, neglect, or exploitation.

PARTICIPANT SIGNATURE	DATE

By signing below, the Assessor attests to the fact that the information used to determine eligibility and document need for services has been obtained from the participant or his/her authorized representative and is believed to be true, accurate, and complete. In addition, the Assessor attests that without authorized HCBS, the participant would, in all likelihood, require nursing facility placement.

ASSESSOR SIGNATURE	DATE	ASSESSOR NAME (PRINTED)	EMPLOYED BY

PARTICIPANTS ARE EXPECTED TO:

- Explain any specific information about tasks authorized on the care plan.
- Provide supplies needed for tasks in the care plan.
- Sign a **completed** timesheet each time you receive services.
- Ensure that information on the timesheet is **accurate**.
- Notify the HCBS provider in advance when you will not be home to receive care.
- Notify the HCBS provider if you have problems with your care delivery.
- Accept or select an aide without regard to race, color, national origin, sex, age, religion, political beliefs, or disability.

PARTICIPANTS HAVE THE RIGHT TO:

- Appeal decisions regarding your person centered care plan, including the denial, reduction, or termination of services.
  - You must appeal within ninety (90) calendar days of the date of the decision.
  - You must request a hearing within ten (10) days of the date of the notice if you wish to continue receiving services pending the hearing decision.
  - If the Division's decision is upheld, you may be held responsible for the cost of any services received while the appeal is pending.
- Appeal any disagreement with decisions about my person centered care plan.
- Receive services without regard to race, color, national origin, sex, age, religion, political beliefs, or disability.

PARTICIPANTS MAY NOT:

- Threaten or abuse or allow other members of your household (or guests) to threaten or abuse provider staff (physically, verbally, or sexually). This will result in your services being terminated.
- Expect care to be provided to your pets, friends, or visitors.
- Allow services to be provided in your home when you are not at home.
- Engage in activities that would be considered fraud of the program; for example signing timesheets attesting to care (or time of care) that has not actually been provided.

PARTICIPANTS of Agency option HCBS:

You may expect your aide to:

- Act in a professional manner.
- Be on time for scheduled visits.
- Notify you if they are unable to deliver services.
- Arrange a make-up visit satisfactory to you.

Do NOT expect your aide to:

- Accept food or drink, except water.
- Accept gifts or tips.
- Give you or anyone in your household, a ride.
- Be a maid.

For your safety, Do NOT:

- Ask your aide for advice.
- Leave valuables, cash, or checkbook in plain sight.

PARTICIPANTS of CDS option HCBS:

You are responsible for:

- Selecting and hiring your aide.
- Training your aide to perform the tasks authorized on the person centered care plan.
- Supervising the work performed by your aide and ensuring the aide is able to meet your personal needs.
- Firing or terminating aides.
- Preparing and submitting timesheets biweekly to the provider that oversees reimbursement for care.
- Ensuring that timesheets are submitted for approved work and that the number of units does not exceed what is authorized on your person centered care plan.
- Receiving care only from aides registered and screened by the Missouri Family Care Safety Registry.