

**MEDICAID WAIVER CONSUMER CHOICE
OF SERVICES/LIVING ARRANGEMENT STATEMENT**

DS 2200 (Rev. 2/2000)

The consumer, parent/legal guardian, or legal representative, or involved other person has been informed of the feasible alternative of services available. The consumer has been offered a choice of receiving such services in a community care residential facility, in an in-home living arrangement, or in a long-term health facility (ICF/DD, ICF/DD-H, or ICF/DD-N).

Consumer Identification Information/Date of Choice

Consumer's Name	Date of Choice (date form completed)
UCI	DOB

Choice of Services/Living Arrangement

I. MINORS

The consumer is a minor. The choice of living arrangement has been made by the parent, legal guardian, or legal representative as indicated in Section III below:

_____ Date

II. ADULTS

a. The consumer is an adult and has chosen the living arrangement as indicated in Section III below:

_____ Date _____ Date
 Client's signature/mark ("X") Witness' signature

The consumer is an adult but is unable to make such choice. The choice of living arrangement has been made by:

- b. The consumer's legal representative; or, if the client has no legal representative
- c. The consumer's parents, relatives or other persons actively involved in the development of the consumer's plan of care;

_____ Date
 Signature

III. SERVICES/LIVING ARRANGEMENT

- A. A long-term health facility (ICF/DD, ICF/DD-H, or ICF/DD-N)
- B. A community care residential facility, or
- C. Consumer's choice of living arrangement other than above (please specify): _____

IV. DISENROLLMENT FROM MEDICAID WAIVER

- A. I choose/my legal guardian/representative chooses to terminate my Medicaid Waiver participation. Since this is my choice, I will not be requesting a fair hearing.

_____ Date
 Signature

V. COMMENTS: