COMMONWEALTH OF PENNSYLVANIA
OFFICE OF LONG-TERM LIVING

FREEDOM OF CHOICE FORM

Participant Name (Last, First, Middle): _____

Participant ID Number: _____

- I have been informed that I may be eligible for Home and Community-Based Services (HCBS).
- I have been informed that enrollment in a HCBS program is my choice.
- I have been informed what services I may receive and my rights and responsibilities under each service.
- Based on the information that has been presented to me, I choose to [*check one*]:

  1. [ ] Receive HCBS such as Waiver services or the Living Independence for the Elderly (LIFE) Program, where available.

  2. [ ] a. Receive services in a nursing facility.
     [ ] b. Receive services in an Intermediate Care Facility/Other Related Conditions (ICF/ORC).

  3. [ ] Receive no services.

- If I choose to receive HCBS, I have the right to choose the agency that will provide each service from among the enrolled Medicaid HCBS providers in my area.
- I have been provided a choice of Service Coordination Entities by the Enrolling Agency.
- I may change my Service Coordination Entity at any time.
- The Service Coordination Entity reviewed the list of available HCBS providers with me.

I have chosen the following agency as my Service Coordination Entity:

_____
Service Coordination Entity name

This form was thoroughly discussed with: _____
Participant/Representative

By: _____ by means of: _____

Service Coordination Agency, Independent Enrollment Broker, or Area Agency on Aging

Translator, Sign Language, Written, Oral, Other (please specify)

_____

Participant/Representative (*Signature*) Date

_____

Service Coordination Agency, Independent Enrollment Broker, or Area Agency on Aging (*Signature*) Date