## **Informed Choice Required Signature Document**

## Person Name:

Date:

Note – Complete the Informed Choice Required Signature Document by obtaining signatures and initials. Retain hard copy document with signatures and initials for later DOM review (if requested)

3. Person Choice			
Option	Presented as Option, based on Screen?		Person's Choice (initial)
•	Yes	No	(
Nursing Facility Placement			
Assisted Living Waiver			
Elderly/Disabled Waiver			
Independent Living Waiver			
TBI/SCI Waiver			
Other (specify):			
Comment:			

Screener:

I have informed the person and/or the person's legal representative of the available DOM-covered long term care options, including alternatives to Nursing Facility placement, based on the results of the PAS and the person's desired services.

Signature	Date	Printed Name	Credentials
explained to me and have indicate the Medicaid program has finance	ited my choice b cial eligibility rec ie DOM with info	by initialing in the appropriate b quirements not addressed as pa	ave had long term care program options ox above. I also have been informed that art of this screen. I authorize the agency o e federal requirements for review and/or
Signed:	Pe	rson/Legal Representative	Date
Signed:		Witness	Date