

## INDIVIDUAL ON WAIVER - AGREEMENT AND RESPONSIBILITIES

Name:

MMIS Billing Number:

I understand that enrollment in the WAIVER is voluntary. I understand that if approved, I will receive home and community-based waiver services instead of receiving services in a nursing facility or a hospital.

I agree to participate in the \_\_\_\_\_ waiver program.

I do NOT want to enroll in the waiver program at this time. I understand that I may apply again if my needs or circumstances change.

## RESPONSIBILITIES

### I UNDERSTAND AND AGREE TO THE FOLLOWING RESPONSIBILITIES:

- I will actively participate in my service planning and implementation of my All Services Plan.
- I will participate and cooperate with assessments to determine my continued enrollment on the waiver and my service needs.
- I will be available to meet with my Case Manager and my team at agreed upon times. My All Services Plan will be monitored and reviewed by my Case Manager. I can contact my Case Manager with any questions or concerns that I have or when changes may need to be made to my All Services Plan.
- I have the freedom to choose of any approved Medicaid provider to deliver waiver services. I will choose to receive services from approved providers who are authorized on my All Services Plan.
- I may be required to pay a patient liability if that is part of my financial eligibility to remain enrolled on Ohio Medicaid.
- I will use other resources available to me, such as private health insurance, to pay for my services before Ohio Medicaid will pay.
- I will contact my Case Manager to report any service disruption or any services not delivered, or if I have a complaint or concern about my providers(s), or about any health or safety issues.
- I received a copy of the Waiver Handbook.

Individual's Signature:

Date (mm/dd/yyyy)

\_\_ / \_\_ / \_\_\_\_

Authorized Representative's Signature (if individual is unable to sign):

Address

City

State

Zip

Case Manager's Signature

Date (mm/dd/yyyy)

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