Virginia Department of Medical Assistance Services

INDIVIDUAL CHOICE – Home and Community-Based Services or Institutional Care Form

Individual Being Screened: _____ **Medicaid ID#:** _____

I.	**SCREENING TEAM DETERMINATION:** Refer to the Medicaid Long-Term Services and Supports Screening Manual. Note: "Individual" refers to the individual being screened and, if applicable, the family member, parent, legal guardian, or authorized representative.
A.	**Individual Meets Nursing Facility Criteria** (Functional Dependency Level, Medical/Nursing Needs Present and Risk for nursing facility or hospital admission within 30 days without services and supports):
	☐ YES *(must be checked to authorize Medicaid Long Term Services and Supports)* ☐ NO
B.	☐ Deterioration in individual's health care condition or changes in available supports prevents former care arrangements from meeting needs.
	Describe:
	☐ Evidence is available that demonstrates individual's medical and nursing needs are not being met (e.g., recent physician's documentation of instability, findings from medical/social service agencies).
	Describe:
C.	**Individual has selected (*please check only one option*):**
	☐ Commonwealth Coordinated Care Plus Waiver Services; OR
	☐ Program for the All-Inclusive Care of the Elderly (PACE) (if available in service area); OR
	☐ Nursing Facility Services.
	☐ Application to a nursing facility for the individual has been made and accepted. Date application was made: Date Accepted if known:
	Facility Name: / Contact Name and Number:

Complete Sections II and III ONLY if Nursing Facility Level of Care Criteria Are Met

II.	**CHOICE AND PAYMENT RESPONSIBILITY**
	Medicaid will pay for someone to come into your home to care for you as long as in-home services will safely meet your needs and is less costly than nursing facility care. The screening team does not authorize the amount of services or times of day or days of week on which services will be provided. These determinations will be made with further assessment conducted by a CCC Plus Care Coordinator and/or Community Provider. You may choose to receive in-home services if there is an available provider in your area, and you have additional support from family and/or friends (including back up support) or are able to maintain health, safety, and welfare without additional help when in-home services are not being provided.
	To stay at home, help in the following areas is needed *(check all that apply):* ☐ Respite ☐ Personal Care ☐ ADLS ☐ Housekeeping ☐ Meal Preparation ☐ Shopping ☐ Laundry ☐ Transportation ☐ Supervision ☐ PERS ☐ Skilled Nursing Needs/Private Duty Nursing Services

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III.	**DOCUMENTATION OF INDIVIDUAL CHOICE (***The following has been presented and discussed with the individual :)*	
	☐	The findings and results of the individual's screening and needs.
	☐	A choice between the Commonwealth Coordinated Care Plus Waiver, PACE (if available in service area) OR Institutional Care (nursing facility),
	☐	For Nursing Facility Choice Only The individual understands when a diagnosis of a mental illness, intellectual disability or related condition exists an evaluation and determination (PASRR Level II) is required to determine if additional services are necessary. If need is indicated from a PASRR Level I Screening, an individual cannot be admitted for Nursing Facility Services until the completion of the PASRR Level II is completed.
	☐	The individual's right to a fair hearing and the appeal process.
	☐	The individual's right to choice of provider(s). If known, insert provider choice name here: _____ OR If the individual is a Commonwealth Coordinated Care Member, the name of the Health Plan and Care Coordinator if known: _____
	☐	The individual's right to choice of service(s).
	☐	The individual's potential to have a patient pay amount, based on his or her income, regardless of the amount of community-based or institutional care received.
	☐	The individual's understands that, by using Consumer-Directed Services, he or she bears the responsibilities associated with employing his or her own personal attendants. *NOTE: DMAS or CCC Plus Health Plans are not the employer for Consumer-Directed Services.*
	☐	The individual's (or authorized representative's) consent to exchange information with the Department of Medical Assistance Services (DMAS) by signing and dating this form. This consent will remain in effect until revoked by the individual (or authorized representative) in writing.

IV **SIGNATURES**

The above information has been discussed with me. I understand that a Care Coordinator (CCC Plus members) or a provider (FFS) will develop a Plan of Care with my assistance based on my needs and my available support. Provider staff is responsible to provide continuous and reliable care. I understand that when there is a lapse in service I am responsible to provide back-up support.

_____	_____	_____	_____
Individual's Signature	Date	Medicaid LTSS Screener's Signature	Date
_____	_____	_____	
Family Member, Parent, Legal Guardian, or Authorized Representative	Date	Indicate Applicable Designation	

Instructions for Completing the DMAS-97
INDIVIDUAL CHOICE – Home and Community-Based Services or Institutional Care Form

Complete this form when authorizing home- and community-based or nursing facility care services.

Section I: Screening Determination

Item A must be checked "YES" or "NO" to indicate if nursing facility placement is authorized.

Item A or at least one of the conditions in B must be completed if authorizing home-and community-based care services.

Item C must be completed to document the individual's choice of institutional services versus waiver services.

Section II: Community-Based Care Choice and Payment Responsibility

Section II must be completed in its entirety if community-based care criteria are met, and the individual chooses home- and community-based care services.

The screener must check services that the individual will need in order to remain at home.

The screening committee must explain to the individual that the screening committee does not authorize the amount of services or times of day or days of week on which services will be provided. The provider agency will make that decision with the individual based on their needs and wishes identified during the screening.

Section III: Documentation of Individual Choice

Section III must be completed in its entirety regardless of whether institutional care or home- and community-based care is chosen by the individual. Please be sure that each item is discussed with the individual.

Section IV: Signatures

Review the statement of understanding with the individual and ensure that all applicable signatures are obtained.

Please remember to obtain the individual's signature that assures the individual was given a choice of providers and was advised of his or her possible patient pay responsibility.

Please remember to obtain the individual's family member, parent, legal guardian or authorized representative's signature and indicate the applicable designation for the person who is signing.

AT RISK:
For waiver services authorization – individuals must also meet the 'at risk' definition in order to receive services. At risk is defined according to 42 CFR §441.302(1): "…. when there is a reasonable indication that a individual might need the services in the near future (that is, a month or less) unless he or she receives home and community based services."