

**CUSTOMER CHOICE**

**Senior Care Act**

**Older Americans Act**

\*\*\*\*\*

\_\_\_\_\_  
Customer Name (First and Last)

\_\_\_\_\_  
Identification Number

The results of the functional assessment of my medical and personal needs indicate that I qualify for long term care services and those services essential to my health and welfare can be provided to me in my home or other community based setting within the program cost limits. **I have been informed that I am functionally eligible to receive services and may opt to remain in the community and receive the services as designated in the Plan of Care.** My signature below indicates I have been informed of this choice and have read my customer rights and responsibilities.

READ THE CUSTOMER RIGHTS AND RESPONSIBILITIES BEFORE PROCEEDING.

My choice is to: (check one)

\_\_\_\_\_ Enter a Nursing Facility

\_\_\_\_\_ Receive Senior Care Act Services as indicated on the Plan of Care

\_\_\_\_\_ Receive Older Americans Act Services as indicated on the Plan of Care

\_\_\_\_\_ Refuse the Recommended Services

It is my choice: (*Senior Care Act only*- check one)

\_\_\_\_\_ To self-direct all or part of the services that are eligible for self-direction

\_\_\_\_\_ Not to self-direct my services

I understand that upon my choosing to receive Community Living Services I have:

- the option to self-direct all or part of the services that are eligible for self-direction,
- free choice of which provider(s) who will provide my needed services, and
- free choice of the case manager who will provide my case management service.

\_\_\_\_\_  
Customer or Authorized Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Case Manager Signature

\_\_\_\_\_  
Date

.....  
Reviewed Customer Choice Form:

Customer Initials:

Date:

CM Initials:

Date:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_