PRINT SAVE

MARYLAND MEDICAL ASSISTANCE PROGRAM
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL DAY CARE SERVICES WAIVER
FREEDOM OF CHOICE CONSENT FORM

Applicant/ Participant Consent (Check selection, sign and date):

____ I choose to receive home and community-based services under the Medical Day Care Services Waiver as an alternative to institutional long-term care services in a nursing facility. I further understand that in order to qualify and continue to qualify for the waiver program, I must meet all eligibility criteria of the Maryland Medicaid Program and the Medical Day Care Services Waiver.

I have received a list of enrolled Medicaid providers and understand that I have the right to select which licensed adult medical day care center I would like to attend. I understand that I may change medical day care centers if I decide to do so and that there are alternative services for which I am eligible, including services in a nursing facility. I have identified and selected the following Medicaid provider to render the medical day care service: Center for Social Change AMDC

____ I choose to receive institutional long-term care services in a nursing facility, rather than through alternative services which have been explained to me. I further understand that in order to qualify and continue to qualify for Medicaid coverage in the nursing facility, I must meet all eligibility criteria of the Maryland Medicaid Program and for nursing facility services.

____ I choose neither option. Explanation (optional):

Print Name: _____ MA#: _____
Applicant/ Participant

Signature: _____ Date: _____
Applicant/ Participant/ Authorized Representative

Witness: _____ Date: _____
(Circle One) Hospital Staff/ AERS/ Supports Planner/ MDC Center Staff