Division of Health Care Financing and Policy (DHCFP)
Aging and Disabilities Services Division (ADSD)
Comprehensive
Statement of Understanding

As an alternative to placement in a long term care facility or medical facility, I have the option to choose a less restrictive environment in the community such as returning to my own home, or choosing a Home and Community-Based Waiver (HCBW) program which will assist me with additional needed services in a community based setting.

☐ HCBW for the Frail Elderly ☐ HCBW for Persons with Physical Disabilities

☐ Transition Services which will assist in leaving a nursing or medical facility to return to the community ☐ Other: ________________________

I may request transition services to return to the community, an HBCW, or choose to reside in a long term care facility. (Pick one)

☐ I choose to transition to the community. ☐ I choose to remain in an institutional setting.

If the transition to the community includes an HCBW, then: (Select all three, or decline)

☐ I choose to participate in the HCBW. I understand that my participation is conditional based on my eligibility for Medicaid and waiver criteria. ______ (Initial)

☐ I verify that I have been given a list of qualified waiver providers. ______ (Initial)

☐ I verify that I participated in the development of my HCBW Plan of Care and will actively participate in the development of all future Plans of Care. ______ (Initial)

OR

☐ I decline to participate in an HCBW. ______ (Initial)

☐ I understand that my services are developed by my personal representative, my case manager, providers of my choice, and me. ______ (Initial)

I choose to communicate by using this method:____

I live in the following community setting: ☐ Own Home ☐ Apartment ☐ Residential Group Home ☐ Assisted Living ☐ With Family
☐ Other:___________________________________

I, or my personal representative, was given a choice of home and community based settings?
☐ Yes ☐ No

I, or my personal representative, was given a choice of case managers? ☐ Yes ☐ No

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Responsibilities for Participation in an HCBW:

I understand I, or my personal representative, have/has the responsibility to:

- Notify my provider(s) and case manager of a change in my Medicaid eligibility.
- Notify my provider(s) of my current insurance information, including the name of other insurance coverage, such as Medicare.
- Notify my provider(s) and case manager of changes in my medical status, service needs, address, and location, or of changes of status of my personal representative.
- Treat all staff and providers appropriately.
- Sign my provider's daily log to verify services were provided.
- Notify my provider when scheduled visits cannot be kept or services are no longer required.
- Notify my provider agency of missed visits by provider agency staff.
- Notify my provider agency of unusual occurrences, complaints regarding delivery of services, specific staff, or to request a change in caregiver.
- Furnish my provider agency with a copy of my Advance Directives, if applicable.
- Establish a back-up plan in case my waiver attendant is unable to work at the scheduled time.
- Understand a provider may not perform services or work more hours than authorized in my service plan.
- Understand a provider may not work or clean for my family, household members or others.
- Contact my case manager to request a change of provider agency.
- Sign all required forms.

I further understand:

- I may be responsible for payment of a portion of the Home and Community-Based Services cost (called patient liability) based on financial eligibility. If patient liability is established, failure to pay may result in the loss of Home and Community-Based Services.

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- I may request a hearing from the Division of Health Care Financing and Policy (DHCFP) if I have not been given a choice of Home and Community-Based Services as an alternative to a long-term-care facility placement, if I am denied this service, or if services are reduced, suspended or terminated. A written request for a hearing must be sent to: DHCFP, 1100 E. William Street, Suite 102, Carson City, NV 89701, within 90 calendar days from the Notice of Decision date.

- I may obtain representation by legal counsel, or a friend, relative or other person, or I may represent myself.

☐ *I,or my personal representative, have read the Statement of Understanding and understand it.*
OR
☐ *The Statement of Understanding was read to me.*

☐ *I will establish the fequency of ongoing contacts with my case manager, but understand that the contacts must be sufficient to address my individual health and safety needs. Contacts may be made by any form of communication available to both the case manager and to me or my personal representative.*

☐ *I may have a personal representative represent me with my waiver services, and to sign waiver forms on my behalf.*
I would like:____ to be my personal representative for waiver services. (If this individual should change, a new Statement of Understanding is required).

____
Recipient Signature Date

If recipient unable to sign, what is the reason:____

____
Personal Representative Date

____
Case Manager Signature Date

Personal Representative's Relationship to Client: ___________________________

Reason for Personal Representative: _____________________________________

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