

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

Recipient Name: \_\_\_\_\_

As an alternative to placement in an institutional setting (i.e. a long term care facility or medical facility), I have the option to choose a less restrictive environment remain in a home and community-based setting (i.e. my own home or assisted living). To assist me with this, I may be eligible for transition services to return to the community or may be eligible for a Home and Community-Based (HCBW) Waiver program, which will provide me with additional needed services in a community-based setting.

Please choose one:

- I choose a home and community-based setting.  
 I choose an institutional setting.

If my choice includes a home and community-based setting, then: (Select all three)

- I choose to participate in the HCBS Waiver. I understand that my participation is conditional based on my initial and ongoing eligibility for Medicaid and waiver services. \_\_\_\_\_ (Initial)
- I verify that I have been given a list of qualified HCBS Waiver providers. \_\_\_\_\_ (Initial)
- I verify that I participated in the identification of my service needs that will be used to develop my HCBS Waiver Plan of Care. I will actively participate in the development of all future Plans of Care. \_\_\_\_\_ (Initial)

- I understand that my services are developed using person centered planning. \_\_\_\_\_ (Initial)

I would like to communicate with my case manager in these ways (pick all that apply):

- Phone    Email    Text Messaging    In-person

I live in:  My Own Home    An Apartment    A Residential Group Home/Assisted Living  
 With Family    Other: \_\_\_\_\_

I know that I can change case managers if I am not happy.  Yes    No

My Responsibilities for Participation in a HCBS Waiver:

I understand I, or legal or designated 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.

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- 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 legal or designated 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 Directive, 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.
- 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.

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*I, or my legal or designated representative, have read the Statement of Understanding and understand it.*

OR

*The Statement of Understanding was read to me.*

AND

*I will establish the frequency 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 legal or designated representative.*

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Recipient Signature

Date

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Printed Name of Legal Guardian/Legally Responsible Individual/Designated Representative

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Reason for Legal/Designated Representation

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Legal Guardian/Legally Responsible Individual/Designated Representative Signature

Date

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Case Manager Signature

Date