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 and remain in a home and community-based setting (i.e. my own home or ~~assisted living~~Residential Facility for Groups). 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 Services (HCBS) 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)

☐ Person Centered Planning was explained to me during the assessment. 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~~Facility for Groups/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 that I, or my legal or designated representative, have/has the responsibility to:

➢ Notify my provider(s) and case manager of a change in my Medicaid eligibility.

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- 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 legal or designated representative.

- Treat all staff and providers appropriately. Provide a safe, non-threatening and healthy environment for my caregiver(s) and case manager.~~.~~

- Sign and/or initial 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.

- Work with my case manager and/or HCBS provider(s) to ~~E~~establish a back-up plan in case my ~~waiver attendant~~caregiver 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 as agreed upon between me and the Residential Facility for Groups/Assisted Living provider.~~ 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.~~

☐ *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.*

☐ *I understand that I will be required to participate in at least one annual home visit.*

☐ *I understand that if case management is my only HCBS Waiver service, a monthly contact with my case manager is required.*

Recipient Signature Date

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

If recipient is unable to sign on their behalf: Reason for Legal/Designated Representation

Legal Guardian/Legally Responsible Individual/Designated Representative Signature Date

Case Manager Signature Date