FREEDOM OF CHOICE

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER

TRAUMATIC BRAIN INJURY (TBI)

I, _____ have been informed that I may be eligible for services provided through either a nursing facility or the TBI Home and Community Based Services Medicaid waiver.

Check One:

_____ I have chosen to apply for the Traumatic Brain Injury Medicaid waiver.

_____ I have chosen to apply for Medicaid State Plan Services and/or another Home and Community Based Services Medicaid waiver.

_____ I have chosen **NOT** to apply for services through a Home and Community Based Services Medicaid waiver at this time.

Applicant Signature		Date
Legal Guardian (as applicable)	Signature	Date
Authorized Representative (as applicable)	Signature	Date
Regional Resource Development Specialist	Signature	Date