Assisted Living Waiver Patient's Rights

Name:_____

Client Identification Number (CIN): _____

This document confirms the following: (Check all that apply)

☐ I had freedom of choice in choosing my services and provider(s).

☐ I had freedom of choice in choosing where I live.

☐ I participated in a person-centered planning process.

☐ My care coordinator explained my rights and responsibilities.

☐ My care coordinator explained my right to a fair hearing.

☐ My care coordinator provided me with their contact information and their supervisor's contact information (if applicable).

☐ My care coordinator discussed setting options, including non-disability settings and options for a private unit.

Care Coordinator Contact Information:

Name: _____

Phone: _____

Email: _____

Care Coordinator Supervisor Name: _____

Care Coordinator Supervisor Phone: _____

Rights Modification Consent (Do not complete if a rights modification does not exist)

My individual service plan includes the modification of my rights, as explained below.

By signing this form, I agree to the services and supports in my individual service plan, including any modification to my rights. I agree to this plan being shared with myself, the people involved in this process, and the people that need it to provide my services.

Individual/Legally Responsible Person (Print Name):_____

_____ _____

Individual/Legally Responsible Person Signature Date

Care Coordinator (Print Name):_____

_____ _____

Care Coordinator Signature Date

Other ISP meeting participants:

☐ Chosen by Individual ☐ Providing Services (if applicable)		
Name:	Title:	Agency:
Signature:	Date:	

☐ Chosen by Individual ☐ Providing Services (if applicable)		
Name:	Title:	Agency:
Signature:	Date:	

☐ Chosen by Individual ☐ Providing Services (if applicable)		
Name:	Title:	Agency:
Signature:	Date:	

☐ Chosen by Individual	☐ Providing Services (if applicable)	
Name:	Title:	Agency:
Signature:	Date:	

☐ Chosen by Individual	☐ Providing Services (if applicable)	
Name:	Title:	Agency:
Signature:	Date:	

☐ Chosen by Individual	☐ Providing Services (if applicable)	
Name:	Title:	Agency:
Signature:	Date:	

If you feel like your rights have been violated contact your Care Coordination Agency or local Ombudsman. The phone number for the local Ombudsman office and the Statewide CRISISline number is 1-800-231-4024. The CRISISline is available 24 hours a day, 7 days a week.