

INITIATION/TERMINATION OF CONSUMER DIRECTED OPTION (CDO)

- SCL**
- MP**
- HCB**
- ABI**

Member Name: _____ Medicaid Member ID #: _____

Case Manager/Support Broker: _____ (Name) _____ (Phone)

Provider Number: _____

Addition of CDO Services Date: _____ Initials: _____

I understand that I have the freedom to choose the Consumer Directed Option for some or all of my waiver services. This has been explained to me and I choose consumer directed services. In making this decision, I understand the following terms of the program:

I understand that I may:

- Train or arrange training for employees necessary for providing care.
- Ask for a change in my Plan of Care (POC)/Support Spending Plan (SSP) if I feel my needs have changed.
- Select a representative to help me with decisions about the CDO.
- Bring whomever I want to all meetings pertaining to the CDO.
- Complain or ask for a hearing if I have problems with my health care.
- Voluntarily dis-enroll from the CDO Program at any time and receive my services through the traditional waiver program.

I understand that I shall:

- Develop a POC/SSP to meet my needs within the Consumer Directed Options (CDO) according to program guidelines and my individual budget.
- Hire, supervise, and when necessary, fire my providers.
- Submit timesheets, paperwork required for my employees.
- Treat my providers and others that work for the CDO program the same way I want to be treated.
- Participate in the development of my POC/SSP and manage my individual budget.
- Complete all the paperwork necessary to participate in the CDO program, and follow all tax and labor laws,
- Be treated with respect and dignity and to have my privacy respected.
- Keep all my scheduled appointments.
- Pay my patient liability as determined by Department for Community Based Services (DCBS), failure to do so will result in termination from CDO.

*For addition of CDO services, attach revised MAP 109 Plan of Care.

Date traditional case management ends and Support Broker begins ____/____/____

Date traditional services end and CDO services begin: ____/____/____



INITIATION/TERMINATION OF CONSUMER DIRECTED OPTION (CDO)

Member Name: _____ Medicaid Member ID #: _____

Representative Designation Date: _____ Initials: _____

I appoint _____ as my representative for the Consumer Directed Option (CDO) Program.

(Address)

(City) **KY** _____ (Zip) _____ (Phone)

Relationship to Consumer: _____

My representative and I understand the following requirements

A CDO representative must:

- Be at least 21 years of age
- Not be paid for this role or for providing any other service to me
- Be responsible for assisting me in managing my care and individual budget
- Participate in training as directed by me and/or my support broker
- Have a strong personal commitment to me and know my preferences
- Have knowledge of me and be willing to learn about resources available in my community
- Be chosen by me

*For voluntary or involuntary termination of CDO service, attach revised MAP 109-Plan of Care.

Voluntary Termination of CDO Services Date: _____ Initials: _____

I choose to terminate my services through the Consumer Directed Option and choose to receive my services through the traditional waiver program.

Involuntary Termination of CDO Services
(To be completed by the Support Broker)

Reason for termination of CDO:

- Health and Safety Concerns
- Exceeding Individual Budget
- Inappropriate Utilization of Funds
- Other (Describe)

Traditional Provider Agency _____
Traditional Provider Number _____

Consumer/Guardian Signature

Date

Representative Signature

Date

Case Manager/Support Broker Signature

Date