Division of Policy and Operations

I. Estate Recovery
Pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1993, states are required to recover from an individual's estate the amount of Medicaid benefits paid on the individual's behalf during a period of institutionalization or during a period when an individual is receiving community based services as an alternative to institutionalization.

In compliance with Section 1917 (b) of the Social Security Act, estate recovery will apply to nursing facility long term care services (NF, NF/BI, ICF/ID/DD), home and community based services that are an alternative to long term care facility services and related hospital and prescription drug services.

Recovery will only be made from an estate if there is no surviving spouse, or children under age 21, or children of any age who are blind or disabled.

I certify that I have read and understand the above information.

____ ______/______/
Signature ***Date***

II. Home and Community Based Waiver Services for the aged and/or disabled, individuals with intellectual or developmental disabilities, Model Waiver II, and Acquired Brain Injury Waiver

A. Acquired Brain Injury (ABI) Waiver - This is to certify that I/legal representative have been informed of the ABI waiver program for adults with an acquired brain injury. Consideration for the ABI waiver program as an alternative to NF or NF/ABI placement ***is requested _______; is not requested _______.***

____ ______/______/
Signature ***Date***

B. Acquired Brain Injury Long Term Care (ABI LTC) Waiver - This is to certify that I/legal representative have been informed of the ABI LTC waiver program for individuals with an acquired brain injury. Consideration for the ABI LTC waiver program as an alternative to NF or NF/ABI placement ***is requested _______; is not requested _______.***

____ ______/______/
Signature ***Date***

C. Home and Community Based (HCB) Waiver - This is certify that I/legal representative have been informed of the HCB waiver for the aged and disabled. Consideration for the HCB program as an alternative to NF placement ***is requested* ________; *is not requested* ________.**

____ ______/______/
Signature ***Date***

D. Model Waiver II (MIIW) - This is to certify that I/legal representative have been informed of the Model Waiver II program for individuals who are ventilator dependent more than twelve (12) hours a day. Consideration for the Model Waiver II program as an alternative to NF placement ***is requested* ________; *is not requested* ________.**

____ ______/______/
Signature ***Date***

E. Michelle P. Waiver (MPW) - This is to certify that I/legal representative have been informed of the MPW program for individuals with an intellectual and/or developmental disability. Consideration for the MPW program as an alternative to ICF/IID or NF placement ***is requested* ________; *is not requested* ________.**

____ ______/______/
Signature ***Date***

F. Supports for Community Living (SCL) Waiver - This is to certify that I/legal representative have been informed of the SCL program for individuals with an intellectual and/or developmental disability. Consideration for the SCL program as an alternative to ICF/IID placement ***is requested* ________; *is not requested* ________.**

____ ______/______/
Signature ***Date***

II. Freedom of Choice of Provider

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.

____ ______/______/
Signature **Date**

III. Resource Assessment Certification

This is to certify that I/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Community Based Services.

____ ______/______/

Signature ***Date***

IV. Recipient Information

Medicaid Recipient's Name: ____

Address of Recipient: ____

____

Phone: (_____)____

Medicaid Number: ____

Responsible Party/Legal Representative: _______________________________________

Address: ____

____

Phone: (_____)____

Signature and Title of Person Assisting with Completion of Form:

____

Signature ***Title***

Agency/Facility:____

Address:____

____