ACKNOWLEDGMENT REGARDING SIB-R RESPONSE BOOKLET

1. Participant requests the following: (check a box)

   ☐ A full copy of Participant's SIB-R Response Booklet(s);

   ☐ Only pages _____ of Participant's SIB-R Response Booklet(s).

2. The Idaho Department of Health and Welfare believes that all parts of the SIB-R Response Booklet(s) that I am requesting are protected by law and cannot be used in violation of applicable law, including copyright law. The Department also believes that disclosure of the SIB-R Booklet(s) (or individual questions and responses) may undermine the value and usefulness of the SIB-R instrument.

WARNING ABOUT COPYRIGHT RESTRICTIONS

The copyright law of the United States (title 17, United States Code) governs the making of photocopies or other reproductions of copyrighted material. Under certain conditions specified in the law, the Department is authorized to furnish a photocopy or other reproduction. One of these specific conditions is that the photocopy or reproduction is not to be "used for any purpose other than private study, scholarship, or research" or other "fair use" under copyright law. If a user makes a request for, or later uses, a photocopy or reproduction for purposes in excess of "fair use," that user may be liable for copyright infringement.

For example, the SIB-R Response Booklet(s) can be used to prepare for and assist the Participant during administrative proceedings and litigation, such as an appeal of the Participant's budget.

3. I, _____ [printed name of the requesting party], am: (check a box)

☐ A participant in the Department's Medicaid Developmental Disabilities Waiver Program; or

☐ Authorized by Participant to request and receive a copy of his or her SIB-R Response Booklet(s).

By signing below, I acknowledge that I have received and read the notices and warnings above.

IF AN AUTHORIZED REPRESENTATIVE REQUESTS THE SIB-R RESPONSE BOOKLET(S), THE PARTICIPANT MUST SIGN BELOW.

Participant, by signing below, states that he or she is the person requesting a copy of his or her SIB-R Response Booklet(s), or that the person below is authorized to request and receive a copy of Participant's SIB-R Response Booklet(s):

Date:_____
Signature of Participant: _____

Signature of Participant's Authorized Representative Who is Requesting Participant's SIB-R Response Booklet:

Date:_____
Signature of Authorized Representative: _____

Return completed form to Medicaid by mail, email or fax.

Mail: Division of Medicaid
Bureau of Developmental Disability Services
P.O. Box 83720
Boise, ID 83720-0009

Email: BDDACM@dhw.idaho.gov

Fax: 208-332-7297