Idaho Department of Health and Welfare
Division of Medicaid

Service and Provider Choice

Name _____MID_____ Date _____

Nurse Reviewer _____ Medicaid Office _____

***Directions*:**
1. For the services checked, select the provider from the enclosed list and **write in the name of agency** below
2. Sign and date the lines below the list of services and agencies selected
3. If applicable, sign and date **Aged and Disabled (A&D) Waiver Choice**
4. Give form to Medicaid Nurse Reviewer or fax or mail in attached stamped envelope
5. Contact the Medicaid Nurse Reviewer if you have any questions **, R.N. at (208) -**
6. Please respond no later than: _____

ADULT PROGRAMS	
☐ Personal Assistance Agency:	☐ Non-Medical Transportation:
☐ Home Delivered Meals:	☐ Nursing Services:
☐ Personal Emergency Response System:	☐ Respite:
☐ Adult Day Health:	☐ Transition Manager:
☐ Other:	
CHILD PROGRAMS	
☐ Personal Assistance Agency:	☐ Nursing Services: PDN
☐ PCS Family Alternate Care Home:	

My signature below confirms I have reviewed the provider list and have chosen the provider(s) and service(s) as indicated above. ☐ Verbal Consent was provided by participant for Provider(s) listed above.

Participant or Representative Signature: _____Date: _____

Aged and Disabled (A&D) Waiver Choice

A & D Waiver services are provided to eligible participants to prevent unnecessary institutional placement; to provide for the greatest degree of independence possible; to enhance the quality of life; to encourage individual choice; and to achieve and maintain community integration. For a participant to be eligible, the Department must find that the participant: Requires services due to a disabling condition which impairs their mental or physical function or independence; and be capable of being maintained safely and effectively in a non-institutional setting; and would, in the absence of such services, require the level of care provided in a Nursing Facility. My signature indicates I was given a choice between waiver services and institutional placement, choice of services under the Waiver and choice of the providers for these services. I also may elect to not utilize waiver services and may choose admission to a nursing facility.

☐ Verbal Consent was provided by the participant.

Participant or Representative Signature: _____ Date: _____