LOCAL COMMISSIONERS MEMORANDUM

DSS-4037EL (Rev. 9/89)

Transmittal No: 93 LCM-179

Date: December 27, 1993

Division: Health and Long Term Care

TO: Local District Commissioners

SUBJECT: Freedom of Choice - Care At Home

ATTACHMENTS: Freedom of Choice Form (from 86 ADM-4) (Available on-line)

As of January 1, 1994 the language in the attached form must be used in the Care At Home Program to indicate that parents are aware that they have freedom of choice. Parents can decide to request the waiver services for home care or decide not to bring their child home without affecting future eligibility.

This form is an attachment (Exhibit 3) in the 86 ADM-4 and has been available as an instrument to indicate that families have a choice. However, over the years different forms have evolved because staff wanted to obtain more information on one form. You may add to this required form any additional information you need. You may place this freedom of choice statement on any other form you feel is applicable, as long as we have this statement signed by the parent(s) on record.

Please contact Janice Tricarico, R.N., M.A. at (518) 473-5840, USER ID 0MA090 with any questions.

Sue Kelly
Deputy Commissioner

I, _____, am the parent of _____, a patient at _____. I understand that the _____ Department of Social Services has determined that my child is eligible for services under a federal waiver program authorized by section 1915(c) of the Social Security Act. I understand the availability to my child of case management, institutional respite services, and other Medicaid services offered by New York state. I have indicated, in the appropriate space below, my decision whether or not to bring my child home to receive these Medicaid services under this waiver program. My decision is voluntary and does not result from coercion or pressure exerted on me by the Department or by the medical institution where my child no resides.

_____ I have decided to bring my child home to receive Medicaid services under this waiver.

_____ I have decided not to bring my child home at this time. I understand that my decision not to bring my child home at this time does not affect my child's eligibility for Medicaid services in the medical institution where my child now resides. I also understand that I may later reapply for services under the program if I should change my mind.

_____
(Parents signature)

_____
(Date)

_____
(Witness)