

**Acknowledgment of Informed Choice  
Self-Directed Services  
Oklahoma Health Care Authority  
Long Term Care Administration**

**Living Choice      Medically Fragile**

<b>Participant Name</b>				
	<i>Last</i>	<i>First</i>	<i>M.I.</i>	<i>SoonerCare ID</i>

Self-Directed Services are offered in the Long Term Care Administration (LTCA) Living Choice Demonstration and the Medically Fragile Waiver that gives you authority and control over who provides your Personal Care and Advanced Supportive/Restorative services and how these services are provided. This opportunity for self-direction and determination also requires you to assume additional responsibilities and perhaps additional risks that you do not have under the existing provider agency service that provides personal care services to you.

**Acknowledgment of Responsibilities for Self-Directed Services**

Please check **Yes** or **No** indicating your agreement with and acknowledgment of the following:

<b>1.</b>	I have received and read the <b><u>Self-Directed Information Handbook</u></b> and understand what will be expected of me.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>2.</b>	I have completed the <b><u>Self-Assessment Tool</u></b> .	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>3.</b>	I understand my <b><u>Roles and Responsibilities</u></b> in receiving <b>Self-Directed Services</b> .	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>4.</b>	I am making a <b><u>Voluntary and Informed Choice</u></b> to receive <b>Self-Directed Services</b> .	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>5.</b>	<p>I understand that I may designate a family member or friend as an <b><u>Authorized Representative</u></b> to assist me in my employer responsibilities to the extent that I prefer.</p> <p><input type="checkbox"/> I understand that by choosing to designate an Authorized Representative that I do not give up any of my decision-making authority.</p> <p><input type="checkbox"/> I understand that an individual hired to provide Personal Care Services to me may not be my designated Authorized Representative.</p> <p><input type="checkbox"/> I understand that I may change my mind and revoke my designation of an Authorized Representative at any time by notifying my Case Manager and the FMS.</p>	<input type="checkbox"/> YES <input type="checkbox"/> NO

6.	<p><b>Do you want to <u>designate an Authorized Representative</u> to assist you in receiving Self-Directed services? By circling yes, you confirm that:</b></p> <p><input type="checkbox"/> You have discussed with your designated Authorized Representative the specific assistance you would like from him/her regarding your Self-Directed services.</p> <p><input type="checkbox"/> You give permission to your Case Manager to contact your designated Authorized Representative listed below:</p> <p>Last Name _____ First Name _____ M.I. _____</p> <p>Address _____</p> <p>Relationship to You: _____</p> <p>Please have your designated Authorized Representative sign below if he or she agrees with the following:</p> <p><input type="checkbox"/> I agree to serve as the Member's designated Authorized Representative and I have read the Self-Guided Orientation.</p> <p>Authorized Representative Signature _____ Date _____</p>	<input type="checkbox"/> YES <input type="checkbox"/> NO
7.	<p><b>I am making a Voluntary and Informed Choice to withdraw from receiving Self-Directed Services effective: _____</b></p> <p>Last Name _____ First Name _____ M.I. _____</p> <p>Address _____</p> <p>Phone _____</p>	<input type="checkbox"/> YES <input type="checkbox"/> NO

\_\_\_\_\_  
Signature of Member \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guardian (if applicable) \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of TC/CM \_\_\_\_\_  
Date