Health and Safety Agreement Template
(To Be Individualized for Client Specific Situations)

(Insert Client's Name Here) (Insert Date Here)

You have applied to (or You are enrolled in) the Utah Medicaid New Choices Waiver program. This program is designed to assist long term residents of institutional settings to return to a home or community-based setting by providing supportive services to help them to reside safely in that setting. New Choices Waiver is required to demonstrate an ability to meet the health and safety needs of each participant on a continuous and ongoing basis.

The New Choices Waiver Eligibility Policy 2-1C states, *"An individual will not be enrolled if it is determined during the eligibility assessment process that the health, welfare, and safety of the individual cannot be maintained through the New Choices Waiver program."* Likewise, if it is determined that a current waiver participant's health and safety needs cannot be met, alternatives must be considered for that individual including potential disenrollment from the waiver.

(Insert Case Management Name Here) has noticed a pattern of non-compliance in your history that is cause for concern for your health and safety. Specifically, you have (describe the behavior in very sensitive terms here). (Insert CMA name here) believes you can be successful and we are dedicated to helping you. We will be monitoring your progress closely to ensure there is sustained evidence that your health and safety needs can be met for the duration of your participation in the program.

In an effort to establish a clear understanding of expectations going forward, this agreement outlines the stipulations that must be met on a continuous and ongoing basis in order to remain enrolled in the New Choices Waiver program:

_____ (Insert a set of clear expectations here. Be reasonable and only include what is expected that, if not met, would result in the CMA recommending disenrollment from the program. For example, if a client was going to be evicted for poor hygiene, do not state that the client must brush their teeth 3 times every day because missing 1 time on a particular day would not result in disenrollment from the NCW program. Instead, require something more reasonable like brushing their teeth regularly and bathing three times per week in order to avoid health problems and social isolation resulting from bad breath and body odor.)

_____ Example of a clear expectation: Refrain from suicide attempts and acts of self-harm. Reach out to one of the following professionals whenever you experience suicidal ideation:

1. a staff member at the assisted living facility where you reside,
2. your case manager with the New Choices Waiver case management agency,
3. the crisis hotline, and/orf
4. your psychiatrist or therapist.

_____ Example: Refrain from misusing medications. Do not obtain or attempt to gain access to prescription medications that are not prescribed for you by your primary care physician. Agree to allow the staff members of the assisted living facility to monitor your medication usage including over the counter medications.

_____ Example: Refrain from excessive alcohol consumption to avoid negative interference with prescription medications.

_____ Example: Refrain from using illicit drugs.

_____ Example: Seek medical attention from your primary care physician before going to the ER when you are experiencing non-emergent pain, illness, injury, or when having complications related to an existing medical condition. Or consult with any of the following individuals:

1. a staff member at the assisted living facility,
2. your home health agency, and/or
3. your New Choices Waiver case manager.

CERTIFICATION OF UNDERSTANDING:

I, (client name), understand this agreement has been created in an effort to establish clear expectations and to assist me to be successful in the New Choices Waiver program.

I understand that if I am unable to meet the terms of this agreement and it is determined that my health and safety needs cannot be met, the Special Circumstance Involuntary Disenrollment process will be initiated.

I understand that if I am disenrolled from the New Choices Waiver program, I will lose the following services that I am currently approved to receive:

1. (Insert all NCW services on the approved care plan.)
2.

_____ _____
Signature – (client) Date

_____ _____
Signature – Waiver Case Management Agency Representative Date

_____ _____
Signature – Waiver Case Management Agency Representative Date

_____

Documentation of client's disagreement with the terms of this contract:

I do not agree with some or all of this contract and I do not wish to abide by the terms listed.

Comments: _____

_____

_____

_____ _____
Signature – (client) Date