New Choices Waiver
Person-Centered Care Plan

My Name: Click here to enter text.	**My Medicaid ID:** Click here to enter text.

As a New Choices Waiver participant I have the following *rights*:

The right to be treated with consideration, respect, and with full recognition of my dignity and my individuality.

The right to medical care and supportive services no matter my race, color, nationality, disability, sex, sexual orientation, religion, or age.

The right to confidentiality of my protected health information. My health information cannot be released to any entity without my permission, unless it is allowed by law for the provision of treatment or payment and healthcare operation activities. I also have the right to obtain copies of my own health information, to dispute information in the record, and to request amendments or corrections to my medical record.

The right to receive education on my health conditions, health related risks, assessed medical needs, and all services available to meet my goals and assessed needs. I have the right to receive this information in a manner and language that is understandable to me.

The right to choose where I will live. I may choose to live in any community based setting as long as my assessed needs can be met in that setting and as long as I can afford the room and board or rental fees in that setting. I may also choose to decline New Choices Waiver services and choose to receive care in a nursing facility.

The right to choose who I will live with. I do not have to share a room with a roommate unless I choose to. If I choose to have a roommate, I have the right to select my own roommate.

The right to have visitors including family, friends, and other visitors of my choosing at any time except when doing so negatively impacts the rights of others or when doing so endangers me, my care providers, or others.

The right to a personalized care plan that is based on my personal strengths, preferences, goals, and assessed needs. I may choose somebody to represent me and to participate in helping me develop my plan of care. I have the right to schedule care planning activities at times and locations that are convenient for me and/or my chosen representatives within the normal business hours of my chosen case management agency.

The right to choose which of the services I will receive from the list of services that my case management agency has assessed to be medically necessary to meet my goals and to ensure my health and safety. I may choose to accept or decline any services that are recommended to me.

The right to select my own service providers. I will be given a list of all available New Choices Waiver providers in my area. My caregivers and case management agency should not prompt, endorse, or encourage the use of any specific service providers. If I choose to live in a non-facility setting, I may also explore the option of hiring my own service provider and have the ability to direct my own care through the self-administered service option.

The right to receive case management services without a conflict of interest. My direct service case manager will counsel me about conflict of interest rights and all potential conflicts will be fully disclosed to me.

The right to keep a copy of my care plan and to request changes to my care plan services, my service providers, or my home setting at any time. To request changes, I will contact my case manager. My care plan will be reviewed and revised at a minimum of annually and whenever my assessed needs change.

As a New Choices Waiver participant I have the following *responsibilities*:

I am responsible to complete the New Choices Waiver application truthfully and submit all requested documentation in a timely manner. Incomplete or inaccurate applications may result in denial or disenrollment from the New Choices Waiver program.

I am responsible to maintain Medicaid financial eligibility. If I do not maintain Medicaid financial eligibility I will no longer be eligible for the New Choices Waiver and I will be financially responsible for any services rendered.

I am responsible to provide complete and accurate information about my medical history, health, and care needs during my initial medical assessment performed by the case management agency. I am further responsible to be truthful and accurate and as they perform additional assessment activities throughout my enrollment in the New Choices Waiver.

I am responsible to drive the development of my care plan by participating in care planning meetings, communicating my strengths, preferences, goals, and needs and voicing my choices clearly to my case managers. If I prefer, I can delegate this responsibility to a chosen representative that I trust. If I have a legal representative, they are responsible to participate in the care planning process on my behalf. When my care plan team and I have come to an agreement about the services and supports to be included in my care plan, I am responsible to fully engage in those services. My care plan will be reviewed and revised at a minimum of annually and whenever my assessed needs change. If at any time I believe my care plan requires a change or that something about my care plan is ineffective, it is my responsibility to contact my case management agency to request a change.

I am responsible to ask my case manager questions if I am ever confused about the New Choices Waiver program, my care plan, the services I am receiving, or if I do not understand what action is expected of me.

I am responsible to notify my case management agency of any changes in my health or circumstances that may impact my eligibility for the New Choices Waiver, my Medicaid financial eligibility, or that may require changes to my care plan.

I am responsible for any risks or consequences that I may experience because I have chosen to decline a recommended service. If my decisions result in a dangerous situation for my health and safety or the health and safety of people around me and I am unwilling to make adjustments to my plan of care that meets minimal health and safety standards, I may be disenrolled from the New Choices Waiver program.

I am responsible to show respect and consideration to my service providers by keeping scheduled appointments or notifying them if I am unable to keep my scheduled appointment time.

I am responsible to pay the shelter costs at the community-based setting I have chosen to live in. This includes room and board, mortgage payments, rent, and utilities.

I am responsible to show respect for the property, comfort, privacy, and rights of others who live around me.

I am responsible to refrain from committing any illegal actions or actions that may result in self-harm or harm against others.

Acknowledgement of Rights and Responsibilities

If I would like to request a change to my care plan including requesting a different provider, I can contact my case management agency to initiate the care plan amendment process.

Case Management Agency Name: Click here to enter text.

Case Management Agency Phone Number: Click here to enter text.

*If any of my rights are denied, I can make a formal complaint to the **New Choices Waiver program office** by calling:*

1-800-662-9651, option 6 or by email to newchoiceswaiver@utah.gov

*I can also submit a formal complaint to the **Division of Medicaid and Health Financing Constituent Services** by calling:*

1-877-291-5583 or by email to tbarkley@utah.gov

I have the right to request a Medicaid Fair Hearing for any of the following reasons:

1. *If I am denied the New Choices Waiver service providers of my choice,*
2. *If I am denied a New Choices Waiver service that I believe I am eligible to receive,*
3. *If any of my New Choices Waiver services are reduced, suspended or terminated,*
4. *If I am disenrolled from the New Choices Waiver program, or*
5. *If I am not given the right to choose between nursing facility care and waiver participation.*

To obtain a copy of the hearing request form, I can ask my case management agency or call the New Choices Waiver program office.

I have been fully informed of and understand my rights and responsibilities as a participant of the New Choices Waiver program. I have been given a copy of my rights and responsibilities along with a copy of this signed acknowledgement page listing contact information to file a grievance or complaint if needed.

Participant Name:	Participant Signature:	Date:
Legal/Authorized Representative Name:	Legal/Authorized Representative Signature:	Date: