

CERTIFICATE OF CHOICE

Title XIX Home and Community Based Waiver  
for the Mentally Retarded and Developmentally Disabled

Program: \_\_\_\_\_

Client's Name: \_\_\_\_\_

Client's Medicaid Number: \_\_\_\_\_

This is to certify that the above named individual was given the opportunity to choose between institutional and home and community based services and has selected by written acknowledgment, or by written acknowledgment of his or her representative, to receive home and community based services.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

\*Under the provisions of Alabama's Waiver, in accordance with the Social Security Act, as amended, applicants for waiver services or a designated responsible party with authority to act on the applicant's behalf will, when the applicant is found eligible for waiver services, be offered the alternative of home and community based services or institutional services.

Signed: \_\_\_\_\_  
(recipient)

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

Signed: \_\_\_\_\_  
(legal representative)

Date: \_\_\_\_\_