* The *Virginia Informed Choice (VIC) is required* for individuals who are newly enrolled or currently have a DD Waiver
* Retain a copy of the signed document in the individual’s file
* Review and complete the VIC with the individual and/or substitute decision-maker (SDM) at the following times:
	+ ***Annually***
* *At Enrollment into the Developmental Disability (DD) Waivers:*
	+ *Building Independence (BI)*
	+ *Family and Individual Supports (FIS)*
	+ *Community Living (CL)*
* *When there is a request for a change in waiver provider(s)*
* *When new services are requested*
* *When the individual wants to move to a new location and/or is dissatisfied with the current provider*
* *When making a Regional Support Team (RST) referral for individuals with a DD Waiver*
	+ *Submit the VIC with the RST Referral to the secure RST mailbox:* *RST.Referrals@DBHDS.virginia.gov*

|  |  |  |  |
| --- | --- | --- | --- |
| Date Completed: Enter date | Individual’s Name: Enter name | Substitute Decision Maker: Enter name  | **Choose Waiver:** Select one |

1. *Discuss each applicable HCBS service* ***prior to*** *assisting the individual with identifying Waiver service options*
2. *Confirm discussion of all applicable waiver service options by checking the options listed below*

|  |  |  |
| --- | --- | --- |
| ***Residential Option*** [ ]  ***N/A*** [ ]  | ***Employment and Day Options*** [ ]  ***N/A*** [ ]  | ***Additional Options*** [ ]  ***N/A*** [ ]  |
| Independent Living Supports *(BI Waiver Only)* | Individual Supported Employment | Peer Mentoring | Community Guide |
| Shared Living | Group Supported Employment | Assistive Technology | Benefits Planning |
| Supported Living | Workplace Assistance Services | Transition Services | Support Coordination |
| In-home Support Services | Community Engagement | Environmental Modifications |
| Sponsored Residential | Electronic Home-Based Services |
| Group Home Residential 4 beds or less | Community Coaching | Employment and Community Transportation |
| Group Home Residential 5 beds or more (RST required) | Group Day Services | Individual and Family/Caregiver Training *(FIS Waiver Only)* |
| ***Medical and Behavioral Support Options*** [ ]  ***N/A*** [ ]  | ***Crisis Support Options*** [ ]  ***N/A*** [ ]  | ***Agency-Directed*** [ ]  ***Consumer Directed*** [ ]  ***N/A*** [ ]  |
| Skilled Nursing *(FIS & CL Waivers Only)* | Community-Based Crisis Supports | Consumer-Directed Services Facilitation *(FIS & CL Only)*  |
| Private Duty Nursing *(FIS & CL Waivers Only)* | Center-Based Crisis Supports | CD Personal Assistance Services\* *(FIS & CL Waivers Only)* |
| Therapeutic Consultation *(FIS & CL Waivers Only)* | Crisis Support Services | CD Respite\* *(FIS & CL Waivers Only)* |
| Personal Emergency Response System (PERS) |  | CD Companion\* *(FIS & CL Waivers Only)* |
| SC has provided the opportunity to talk with other individuals receiving BI/FIS/CL Waiver services who live and work successfully in the community or with their family members Yes [ ]  No [ ]   | *You may contact a DBHDS Family Resource Consultant at (804) 894-0928 or (804) 201-3833 to connect with individuals and families who have waiver services* | *Provider options are available on the DBHDS Licensing website and the DBHDS Provider Survey* [*http://lpss.dbhds.virginia.gov/LPSS/LPSS.aspx*](http://lpss.dbhds.virginia.gov/LPSS/LPSS.aspx)[*http://ejiujiu0.wixsite.com/providersurvey*](http://ejiujiu0.wixsite.com/providersurvey) |

3. List multiple providers in each section if applicable and indicate option selected

 In making a decision, I/we considered the following Options:

| Options | Provider Agency, Location (City) and Bed Capacity | Option Selected | Reason(s) Be specific. |
| --- | --- | --- | --- |
| **Support Coordination** | Enter agency | SC Name | Enter reason |
| Select item | Enter provider information | Provider | Enter reason |
| Select item | Enter provider information | Provider | Enter reason |
| Select item | Enter provider information | Provider | Enter reason |
| Other | Enter provider information | Provider | Enter reason |
| Other | Enter provider information | Provider | Enter reason |
| Other | Enter provider information | Provider | Enter reason |

I may contact my Support Coordinator/Case Manager (SC/CM) to seek assistance with resolving provider-related issues. I have the option of changing providers, including my SC/CM. I have the right to a fair hearing and appeal process. I may be responsible for some service cost (patient pay), based on my income. If I chose Consumer-Directed Services, I am responsible for employing my own personal assistants and know there are services in the BI/FIS/CL Waivers that require a backup plan if there is a lapse in services. I will actively participate in the development of my Person-Centered Individual Support Plan.

**My SC/CM discussed the above information with me.**

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Individual Signature/Date SDM Signature (if applicable)/Date SC/CM Signature/Date

Regional Support Team referral is REQUIRED if any of the following criteria apply Community: Select one Training Center: Select one