

Virginia Informed Choice Form Protocol

The **Virginia Informed Choice Form (VIC)** is required for individuals who are newly enrolled or currently have a DD Waiver. A copy of the signed document should be retained in the individual's file.

The Virginia Informed Choice Form (VIC) is required for individuals who are newly enrolled or currently have a DD Waiver. A copy of the signed document should be retained in the individual's file.

It is the Support Coordinators responsibility to inform/discuss with the individual and/or substitute decision-maker all Home and Community Based services available to them. This should be a discussion about the services that are available within the waiver received by the individual. All services should be discussed whether or not there are providers for the services in your area, and there should be a note documenting the conversation taking place. The Virginia Informed Choice form should reflect the conversation.

Support Coordinators provide individuals and/or their decision-makers the **Service Selection Guide** as a tool to help them understand the full range of services and providers available under the DD Waivers. The guide provides clear descriptions of the services under each DD Waiver type. By providing the guide in advance of the meeting (and reviewing during the informed choice process), the Support Coordinator ensures that the individual knows of all service options and can document options clearly.

Review and complete the VIC with the individual and/or substitute decision-maker (SDM) at the following times:

- Annually- This means no more than 12 months from the last Informed Choice Form
- At Enrollment into the Developmental Disability (DD) Waivers:
- Building Independence (BI)
- Family and Individual Supports (FIS)
- Community Living (CL)

All available Home and Community Based services should be discussed with the individual before assisting the individual with identifying the waiver services options for the services they have chosen. If a service is not offered, there should be a note explaining why.

- When there is a request for a change in waiver provider(s) –any time the individual and/or the substitute decision maker asks for a change in providers. This could be multiple times within the PC-ISP year.
- When new services are requested- anytime the individual and/or the substitute decision ask for a new service, this could be multiple times a year
- When the individual wants to move to a new location: -if the individual and/or the substitute decision maker want to move to a new location, even within the same provider.
- When the individual is dissatisfied with the current provider- if the individual and/or substitute decision maker are not satisfied with services, the support coordinator should discuss what is causing dissatisfaction, and if it cannot be resolved, then all services should be reviewed and a VIC completed.
- When making a Regional Support Team (RST) referral for individuals with a DD Waiver

For anyone needing a Regional Support Team Referral, submit the VIC with the RST Referral through the Waiver Management System at <https://www.wamsvirginia.org/>

Note:

SDM = Substitute Decision-Maker (e.g. Legal Guardian or Authorized Representative)

BI = Building Independence Waiver

FIS = Family and Individual Supports Waiver

CL = Community Living Waiver

PA = Personal Assistance

Completing this form with requested information satisfies Licensing regulations 12VAC35-105-1240.12 and 12VAC35-105-660.D. 1-2 for case management and meets informed choice expectations under DD Medicaid waiver requirements.

Note: There are two options included one for keyboard entry and one written version. Choose one of the two options when completing the form. For settings with five or more beds, this form is completed in the Waiver Management System (WaMS).

Virginia Informed Choice Form

Date: _____ Name: _____ SDM: _____ Waiver Type: _____

I received the Service Selection Guide and understand my options. I reviewed services and providers available to me and select the following options for all DD Waiver services I currently receive including the changes I make today:

1. For support coordination, I select: _____ Name of selected SC: _____

2. Did you request assistance with contacting Family-to-Family or Peer Mentoring? Yes No

2a. If yes, did your SC provide support? Yes No

3. For support where I live, I select: _____ Agency selected (as applicable): _____

4. For support with work, I select: _____

5. For support in my community, I select: _____

6. For other services, I select: _____

7. Are any desired services unavailable in current waiver?

Yes No

7a. If yes, briefly describe steps taken or planned to resolve any related concerns:

8. My support coordinator has discussed these services, and any alternatives available within my community, with me and I select these knowing the associated benefits and risks.

Yes, I confirm.

9. The reason for completing this form is:

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. I 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.

Individual Signature/Date

SDM Signature (if applicable)/Date

SC/CM Signature/Date

Virginia Informed Choice Form

Date completed:

Name:

SDM:

Waiver Type:

I received the **Service Selection Guide** and understand my options. I reviewed **services and providers available to me** and select the following options for **all DD Waiver services I currently receive including the changes I make today**:

1. For **support coordination**, I select:

Name of selected SC:

CSB Name _____

SC Name _____

2. For **support where I live**, I select:

Agencies selected:

Independent Living Supports (BI) _____

SharedLiving _____

SupportedLiving _____

In-home Support Services _____

SponsoredResidential _____

Group Home 4 beds or less _____

Non-waiver Community Option _____

GroupHome5+beds **IF RST, complete VIC in WaMS**

Provider: _____

3. For **support with work**, I select:

Individual Supported Employment _____

Group Supported Employment _____

Workplace Assistance Services _____

Non-waiver Community Option _____

4. For **support in my community**, I select

Community Engagement _____

Community Coaching _____

Group Day Services _____

Non-waiver Community Option _____

5. For **other services**, I select:

Community Guide _____

Skilled Nursing (FIS & CL) _____

Private Duty Nursing (FIS & CL) _____

Therapeutic Consultation (FIS & CL) _____

Personal Emergency Response System _____

Community-Based Crisis Supports _____

Center-Based Crisis Supports _____

Crisis Support Services _____

Peer Mentoring _____

Assistive Technology _____

Benefits Planning _____

CD Service Facilitation (FIS & CL) _____

Emp & Community Transportation _____

Non-waiver Community Option _____

CD Personal Assistance (FIS/CL only)

CD Respite (FIS/CL only) ☐CD Companion (FIS/CL only) ☐

9. The reason for completing this form is (select one)

☐ Annual Review☐ New service request☐ RST Referral☐ Enrollment☐ Changing Provider(s)☐ Dissatisfied

6. If you requested assistance with contacting the Family-to-Family or Peer Mentoring, did your SC provide support:

☐ Yes☐ No☐ N/A

7. Are any desired services unavailable in current waiver?

☐ Yes☐ No

7a. If yes, briefly describe steps taken or planned to resolve any related concerns:

Environmental Modifications _____

Electronic Home-based Services _____

Indv. and Family Caregiver Training _____

AD PA (FIS/CL only) _____

AD Respite (FIS/CL only) _____

AD Companion (FIS/CL only) _____

Transition Services ☐

8. My support coordinator has discussed these services, and any alternatives available within my community, with me and I select these knowing the associated benefits and risks.

☐ Yes, I confirm

I may contact my Support Coordinator (SC) to seek assistance with resolving provider-related issues. I have the option of changing providers, including my SC. 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. I 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 discussed the above information with me.

Individual Signature/Date

SDM Signature (if applicable)/Date

SC/CM Signature/Date