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: Select one

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:**

Select CSB/BHA

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):**

Select service

Select service

Select service

4. For support with work, I select:

Select service

Select service

Select service

5. For support in my community, I select:

Select service

Select service

Select service

6. For other services, I select:

Select service

Select service

Select service

Select service

Select service

Select service

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:

Select 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. 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

Written Option

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) ☐

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**

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

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

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**