

CHAPTER 4

FREEDOM OF CHOICE

Once it is determined that an individual has needs that could likely be met either in an ICF/MR or in the community with the provision of waiver services, you must:

- inform the individual, or his/her legal guardian, of the feasible alternatives under the waiver,
- give the individual, or his/her legal guardian, a choice of institutional (ICF/MR) services or home and community-based (ID/RD Waiver) services, and
- inform the individual, or his/her legal guardian, of his/her right to request reconsideration of an adverse decision.

The **Freedom of Choice (ID/RD Form 1)** is used to document that you provided this information and gave the potential recipient the choice of services. Please note that the **Freedom of Choice (ID/RD Form 1)** does not have to be completed prior to the Level of Care; however, the **Freedom of Choice** form must be signed and “home and community-based services” chosen before the individual is enrolled in the Waiver. To meet compliance standards, the **Freedom of Choice** Form must be signed prior to completing the Level Of Care Determination. Also, please see Chapter 6 (*Enrollments*) for more information.

As stated, the **Freedom of Choice (ID/RD Form 1)** form must be signed and “home and community-based services” selected **prior** to waiver enrollment. The presence of this completed and signed form assures that you have explained the services available through the waiver and provided sufficient detail about both ICF/MR and waiver services for an informed choice to be made.

Additionally, a completed and signed **Freedom of Choice (ID/RD Form 1)** signifies that you have informed the recipient of his/her right to request reconsideration if he/she feels a choice of either institution or waiver services was not offered, he/she was not informed of feasible alternatives, was denied services of his/her choice, or was denied services from the provider of his/her choice. Once reconsidered, if the person wishes he/she may appeal to the SC Department of Health and Human Services.

When completing the Freedom of Choice (ID/RD Form 1) a home visit will be made with the consumer and/ or family. Two copies of the Freedom of Choice (ID/RD Form 1) will be

prepared and when explained and a choice made, both copies signed. One copy will be placed in the individual's file. Since the decision remains in effect until the individual/legal guardian changes his/her choice, this form will be a permanent part of the file and will not be removed or purged. The second signed copy of the form will be left with the individual/legal guardian.

Please note: if the initial Freedom of Choice form is signed by the parent or guardian of a minor, the form must be signed by the individual when he/she reaches the age of majority (age 18 in South Carolina) if he/she is not adjudicated incompetent. This will be done by completing a new FOC Form (ID/RD Form 1) or the individual can simply sign the current form. This will be done within thirty (30) days of the individual's eighteenth birthday.

After completing the **Freedom of Choice Form (ID/RD Form 1)**, you will present the individual and/or his/her legal guardian with the **Acknowledgement of Rights and Responsibilities (ID/RD Form 2)**. You must carefully explain and review this information with the individual and/or his/her legal guardian and have the individual sign **the Acknowledgement of Rights and Responsibilities Form (ID/RD Form 2)** if they are over the age of 18 or the family member/legal guardian if the recipient is under 18 or cannot sign for himself or herself. You must also sign the form. This form **will be completed each year at the annual plan meeting.** Again, two copies should be prepared. One left with the consumer and/or legal guardian and the other copy will remain in the active file. For file maintenance, the current copy and the previous copy will be kept in the active file. Prior copies may be purged into the back-up file.

**SOUTH CAROLINA DEPARTMENT OF
DISABILITIES AND SPECIAL NEEDS**

ID/RD WAIVER

FREEDOM OF CHOICE

Individual's Name: _____

Address: _____

Phone #: _____

(Please type or print)

This is to certify that the above named individual was informed of the feasible alternatives under the waiver, given the opportunity to choose between institutional and home and community-based services and was informed of the right to have adverse decision reconsidered. The individual has selected by written acknowledgment, or by the written acknowledgment of his or her representative, to receive the option marked below.

Signature: _____ Date: _____
Service coordinator/early interventionist

Service coordinator/early interventionist's Name: _____

Address: _____

Phone #: _____

(Please type or print)

I, or my authorized representative, have been afforded an opportunity to make an informed choice of receiving either institutional or home and community-based services. My and/or my representative's signature below indicates that at this time, I have chosen to receive:

- home and community-based services (ID/RD waiver)**
 institutional services (ICF/MR)

In the event that I have not been informed of feasible options under the waiver or been given the option of institutional or waiver services, I understand that I have the right to request reconsideration of adverse decisions.

Recipient's Signature: _____

Date: _____

Representative's Signature: _____

Date: _____

Representative's Name: _____

Representative's Address and Phone #, if different from Recipient's: _____

SCDDSN RECONSIDERATION PROCESS

The South Carolina Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Intellectual Disability-Related Disabilities (ID-RD) Waiver, the Community Supports (CS) Waiver, the Head and Spinal Cord Injury (HASCI) Waiver, and the Pervasive Developmental Disorder (PDD) Waiver. If a Waiver participant disagrees with a decision made and/or action taken by SCDDSN, reconsideration and reversal of the adverse decision/action may be requested.

The SCDDSN reconsideration process must be completed in its entirety before seeking an appeal with the South Carolina Department of Health and Human Services (SCDHHS), which is the State Medicaid Agency.

A request for a SCDDSN reconsideration of an adverse decision/action must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision/action. The request must clearly state the basis of the complaint, previous efforts to resolve the complaint, and relief sought. If necessary, a Case Manager or other staff may assist the participant, legal guardian or representative in requesting reconsideration. The request must be dated and signed by the participant, legal guardian or representative assisting the participant. The request for reconsideration must be mailed to:

**State Director
SC Department of Disabilities and Special Needs
P.O. Box 4706
Columbia, SC 29240**

The State Director or a designee will issue a written decision within ten (10) working days of receipt of the written reconsideration request and mail it to the participant, legal guardian or representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written notification.

Note: In order for affected Waiver services to continue during the SCDDSN reconsideration process and the SCDHHS Medicaid appeal process, the participant, legal guardian or representative's request for SCDDSN reconsideration must be submitted within ten (10) calendar days of receipt of written notification of the adverse decision/action. Continuation of the affected Waiver services must be specifically requested in the request for SCDDSN reconsideration. If the adverse decision/action is upheld, the participant or legal guardian may be required to repay the cost of affected Waiver services received during the time of the reconsideration/appeal processes.

SCDHHS MEDICAID APPEAL PROCESS

If the participant, legal guardian or representative fully completes the SCDDSN reconsideration process above and is dissatisfied with the result, the participant, legal guardian or representative has the right to request an appeal with the State Medicaid Agency, which is the South Carolina Department of Health and Human Services (SCDHHS). The appeal request may be made electronically using the SCDHHS website indicated below or it may be mailed to SCDHHS. This must be done no later than thirty (30) calendar days after receipt of the SCDDSN notification.

The purpose of a SCDHHS administrative appeal is to prove error(s) in fact or law pertaining to a decision made and/or action taken by SCDDSN that adversely affects a Waiver participant. The appeal must clearly state the specific issue(s) that are disputed and what action is requested. A copy of the reconsideration notification received from SCDDSN must be uploaded using the SCDHHS website indicated below or included with the mailed appeal.

The participant, legal guardian or representative is encouraged to file the appeal electronically at www.scdhhs.gov/appeals.

OR

The appeal request may be mailed to:

**SC Department of Health and Human Services
Division of Appeals and Hearings
P.O. Box 8206
Columbia, SC 29202-8206**

An appeal request to SCDHHS is valid if filed electronically or mailed to the above address and postmarked no later than the thirtieth (30th) calendar day following receipt of the SCDDSN reconsideration notification. Unless a valid appeal request is made to SCDHHS, the SCDDSN reconsideration decision will be final and binding.

If a valid appeal request is made, the participant, legal guardian or representative will be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request, which may include a scheduled hearing.

**SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MENTAL RETARDATION/RELATED DISABILITIES (ID/RD) WAIVER**

ACKNOWLEDGEMENT OF RIGHTS AND RESPONSIBILITIES

Name: _____

I acknowledge that this information is to assist me in understanding the Mental Retardation/Related Disabilities (ID/RD) Waiver, my rights, my responsibilities, and my benefits. I will keep this information in a place where I can find it. I can contact my Service Coordinator/Early Interventionist at _____ if I have any questions or need assistance.

I. By receiving services through the Mental Retardation/Related Disabilities (ID/RD) Waiver:

1. I have the right to be treated with dignity and respect by my Service Coordinator/Early Interventionist and all providers of my ID/RD Waiver services.
2. I have the right to confidentiality.
3. I have the right to receive a full explanation of all the forms that I am asked to sign.
4. I have the right to be told about all services available from SCDDSN.
5. I have the right to know the name of my Service Coordinator/Early Interventionist and how I can contact him or her.
6. I have the right to participate in the development of my single plan/IFSP/FSP, have my single plan/IFSP/FSP explained to me and a copy provided.
7. I have the right to choose the agency or provider for each of my ID/RD Waiver services from all qualified/enrolled providers (a list for each ID/RD Waiver service is available online at www.state.sc.us/ddsn/). My decision to receive services from a provider cannot be based on race, color, sex, religion or national origin.
8. I have the right to contact providers to evaluate service quality and gather information to assist in making an informed choice.
9. I have the right to change my provider by notifying my Service Coordinator/Early Interventionist.
10. I have the right to request reconsideration and appeal if I disagree with any decision or action concerning my services or participation in the ID/RD Waiver.
11. I have the right to complain about waiver services/providers by contacting my Service Coordinator/Early Interventionist.
12. I have the right to discontinue participation in the ID/RD Waiver by contacting my Service Coordinator/Early Interventionist.
13. I have the right to be informed about any potential risk associated with waiver services. I have the right to assume that risk and be responsible for any consequences.
14. I have the right to refuse to participate in a ID/RD Waiver service, but understand that I must receive a ID/RD Waiver service at least every thirty (30) days. If I do not receive a ID/RD Waiver service at least every thirty (30) days, I will be terminated from the ID/RD Waiver. I will receive written notification of this termination which will include the processes for reconsideration and appeal of the decision.

II. As a ID/RD Waiver participant:

1. I will treat my Service Coordinator/Early Interventionist and service providers in a considerate, respectful and courteous manner and will expect the same treatment in return.
2. I will inform my Service Coordinator/Early Interventionist and all service providers in advance when I will be away from my home on dates of scheduled services/visits.
3. I will be present at the time of the provider's scheduled visits.
4. I will admit the service provider into my home.
5. I will not ask the service provider to perform tasks that are against the law or that are not a part of my single plan/IFSP/FSP.
6. I understand the ID/RD waiver will not provide for all of my service needs.
7. I will follow the agreed upon single plan/IFSP/FSP.
8. I will provide accurate and complete information about:
 - past and present medical histories;
 - my family or others who can provide supports;
 - other services being provided to me;
 - changes in my condition or situation, i.e. hospitalization, additional caregiver(s), income, and other events impacting my care;
 - changes in my address, phone number(s) and persons assisting me with my care; and
 - timekeeping records that I may be required to sign in regards to Personal Care, Respite or Companion services.
9. I understand that the ID/RD Waiver and DDSN do not provide emergency care. In case of medical emergency, I must contact my physician, go to the hospital or call 911.
10. I understand that I must be available for and participate in my annual plan meeting and that not participating may lead to the suspension of my waiver services.
11. I realize that if I am non-responsive to requests from DDSN, Service Coordinators, or Early Interventionists in efforts to perform periodic evaluations and follow-up procedures, it could possibly result in delay, suspension, or termination of services.

I understand that not abiding by the rights and responsibilities indicated in this document may lead to the termination of waiver services.

Signature of ID/RD Waiver Participant
(if age 18 years or older)

Date

OR

Signature of Parent/Legal Guardian
(if ID/RD Waiver Participant is under 18 years of age)

Date

Signature of Service Coordinator/Early Interventionist

Date