

**DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES
CHOICE OF SERVICE SYSTEM - CSW**

I have received a copy of the FACT sheet, which provides information about services from intermediate care facilities for persons with mental retardation as well as the Home and Community Based Waiver programs. I understand that I can ask for more information and can contact any of the entities included on the FACT sheet for information. If my situation changes in the future, I understand I am free to make a different choice if I am eligible for services.

I have been advised that I may choose either a Home and Community-Based Waiver service or an intermediate care facility for people with mental retardation. I understand the service options well enough to make an informed decision about which services are best for my situation and I choose:

Home and Community-Based Waiver services. Intermediate care facility services.

Person: _____

Date: _____

Support Coordinator: _____

Date: _____

Person's Legal Representative: _____

Date: _____