

New Jersey Department of Human Services

**AGREEMENT OF UNDERSTANDING
HOME AND COMMUNITY BASED SERVICES (HCBS) MEDICAID WAIVER PROGRAMS**

Name of Applicant (<i>Last, First, MI</i>)		Date
Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Medicaid Number
HCBS WAIVER SELECTION (<i>Check only one</i>) <input type="checkbox"/> AIDS Community Care Alternatives Program (ACCAP) Waiver <input type="checkbox"/> Community Resources for People with Disabilities (CRPD) Waiver <input type="checkbox"/> Global Options for Long-Term Care (GO) Waiver <input type="checkbox"/> Traumatic Brain Injury (TBI) Waiver <input type="checkbox"/> Other: _____		

INSTRUCTION: *To be completed by the applicant after Options Counseling has been provided by a representative of the Assessment Agency* or person conducting the program eligibility and comprehensive assessment review.*

The following has been reviewed with me by a representative of the Assessment Agency and I have received a copy. If I am determined eligible and choose to participate in the above selected HCBS Medicaid Waiver, I acknowledge that:

1. I have received information about the services available under the Medicaid Waiver program.
2. The clinical and financial eligibility criteria that are required to participate in the specified program as well as the enrollment process for this program have been explained to me.
3. I require and agree to accept the minimum number of Waiver services required as specified by each individual Waiver program.
4. My primary caregiver (if applicable) _____ and I agree to share in the implementation of the Plan of Care and accept the specific responsibilities outlined therein.
5. The New Jersey Medicaid Program pays for authorized services but cannot guarantee that services will be provided as requested.
6. I have the right to choose my Waiver service provider(s), as available.
7. My case/care manager will assist me in arranging and coordinating services but will not provide direct care. I will meet with my care/case manager on a regular basis as required by the Waiver program in which I am enrolled.
8. There are financial limits on the amount of money that can be expended on my care in the community under the Waiver program.
9. Retroactive eligibility is not available to Waiver participants; no Waiver service(s) received prior to the date of enrollment shall be reimbursed through the program.
10. If I am applying for the CRDP Waiver in order to obtain private-duty nursing (PDN) services, I must have a live-in primary caregiver (adult relative or significant other adult) who accepts 24-hour responsibility for my health and welfare.
11. If I am determined eligible for the GO Waiver, and choose to reside in either an Assisted Living facility or Adult Family Care setting, there may be a Cost Share, which is dependent on my income and allowable deductions, as permitted by the program and calculated by my Care Manager.

Name of Applicant (<i>Print</i>)	Signature of Applicant X	Date
Name of Legal Representative, If Applicable	Signature of Legal Representative, If Applicable X	Date

* For applicants of the TBI, CRPD, and ACCAP Waivers, the function of assessment is only done by the Regional Office of Community Choice Options (OCCO).