WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

West Virginia (WV) Children with Serious Emotional Disorders (CSED) Waiver Freedom of Choice Form

Completed annually or as chosen by the child/adolescent receiving services.

Member Information

First Name, MI, Last Name			
Phone Number		Date of Birth	
Street Address (City, State, Zip Code) **Proof of residency must be attached*			

Home and Community Based (HCBS), Assertive Community Treatment (ACT), or Psychiatric Residential Treatment Facility (PRTF) Level of Care Choice

If you qualify for the level of care provided in a PRTF, you have the right to choose between receiving services/supports in a PRTF or your home and/or community. The West Virginia CSED Waiver Program provides services/supports in your home and community. Please initial your choice for services/supports:

Initial	**I choose to receive support in my home and community through the WV CSED Waiver Program. I understand that I have the following rights:** • The right to choose among qualified providers, • The right to choose a different provider if I prefer, • The right to a fair hearing through the Bureau for Medical Services if I am not given a choice.
Initial	**I choose to receive support in an ACT program.** (Only if criteria are met).
Initial	**I choose to receive support in a PRTF and not in my home and community.**
Initial	**I choose to not participate at this time and acknowledge I can reapply at any time. I understand that I meet HCBS criteria,**

Agency Choice

You have the right to choose from among qualified providers in your area.

Initial	All enrolled providers in my catchment area have been discussed with me. I understand that I may choose any qualified provider in my area for each of my services. **The agency that I choose to provide my Wraparound Facilitator is**:	
	The First Available ☐	Other
Initial	**The agency that I choose to provide all other CSEDW Services is:**	
	The First Available ☐	Other

Signature of Participant	**Date**	**Legal Representative Signature**	**Date**
Acentra or Aetna Representative Name	**Date**	**WF Agency Representative Name**	**Date**