Developmental Disabilities Administration
Community Pathways Waiver
Freedom of Choice

Individual's Name _____ (*FIRST, MIDDLE, LAST*)

I understand that there are alternative services for which I may be eligible, including services in the community under the waiver, in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID), and licensed nursing/rehabilitation facility. I understand and have considered my options which have been explained to me. I further understand that in order to receive, and continue to receive home and community-based waiver services, I must meet all the eligibility criteria of the Maryland Medical Assistance program and DDA Waiver program.

Please check your choice in services to be received:

☐ I choose to receive home and community-based services under the Maryland Medical Assistance Program/DDA Community Pathways Waiver

☐ I choose to receive services in an institution (ICF/ID)

☐ I choose to receive services in a licensed nursing/rehabilitation facility

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Acknowledgement of the choice of waiver service delivery model:

The Community Pathways Waiver offers two service delivery models including traditional/provider managed and self-directed services. Individuals may choose a combination of the two.

Please check your choice in services to be received:

☐ Traditional/Provider Managed Services
☐ Self-Directed Services
☐ Combination of Traditional and Self-Directed Services

Acknowledgement of the various waiver services and providers:

I have been advised of the various waiver services and providers licensed by the DDA and informed of my right to choose providers that meet my needs and preferences.

Signature: _____
Individual

Or: _____
Legally Authorized Representative or Guardian/Parent (if applicable)

Signature: _____ _____
Resource Coordinator Date