A Brighter Choice

Consent/Information Acknowledgment/Authorization Form
Updated Annually

Participant: _____ MA#: _____

DOB_____SS#_____ Adjudicated__ Non-Adjudicated__

Guardian Name/Family Rep _____ Contact #_____

A Brighter Choice is acting as the billing agency for, who will be providing Community Guide Services.

ACKNOWLEDGEMENT: _____
I understand that A Brighter Choice will be billing Kentucky Medicaid for services provided by ReSOARces.

ACCESS TO THE PARTICIPANT'S RECORD:_____
To ensure compliance with Medicaid regulations, I understand that A Brighter Choice will have access to Participant's records that are maintained by ReSOARces.

PARTICIPANT RIGHTS: _____
I acknowledge that I have rights as a participant in a Kentucky Medicaid program. I also have rights granted by state and federal law. My rights have been reviewed with the participant, guardian/family representative and understand I may ask my Case Manager for additional explanation and/or support in exercising these rights. I understand my Case Manager is a

primary advocate for my rights in the Supports for Community Living or Michelle P. Program. Some of the rights included are the right to have privacy, confidentiality, freedom from abuse/neglect, freedom to send/received opened mail, freedom of movement, freedom to file complaints and all other rights listed on the attached Participants Rights Consent. I understand that if I have been adjudicated and have a legal guardian, that my guardian will act on my behalf in making decisions.

GRIEVANCE REPORTING PROCEDURE: _____
I understand that each provider must have a grievance procedure and complaint process. A Brighter Choice, has a procedure that includes notifying the agency of the grievance issue, completing a grievance form and working with the agency to investigate and attempt to resolve the issue. I also understand that my case manager will assist me in filing any grievances with MPW/SCL providers from who I receive services.

At no time will a decision to file a grievance or appeal a decision have a negative effect on the participant.

If resolution to the grievance is not reached, I acknowledge that I may also contact outside agencies to assist me with a grievance issue, or if I wish to file a complaint outside the agency grievance process. Among the outside agencies and may contact: Protection and Advocacy at 1-800-372-2988 and Department of Behavioral Health Division of Intellectual and Developmental Disabilities at 502-564-7702, or the Council on Intellectual Disabilities at 502-584-1239. I may also contact the local department for community-based services if I wish to report an abuse/neglect allegation, and that hotline number is 1-800-752-6200.

INFORMATION ON THE OTHER PROVIDERS:_____
I understand I can ask my Case Manager or the administrative staff of A Brighter Choice, for a list of all Supports for Community Living or Michelle P. Waiver providers in the state at any time. I can also request a list from the Department of Behavioral Health Division of Intellectual or Developmental Disabilities at 502-564-7702.

NOTIFICATION: _____
I understand it is standard procedure of A Brighter Choice, to notify the legal representative of any serious incidents such as emergency room visits, hospitalization, abuse/neglect allegations etc., and to notify me during routine conversations of minor incidents such as minor behaviors, minor medication errors. This includes all incident reports both minor and critical unless otherwise indicated here:

QUALITY OF SERVICE: _____
I acknowledge that it is the responsibility of the participant/ guardian or any other interested party to notify A Brighter Choice of any dissatisfaction of services provided or any other issues that would relate to concerns involving the billing of services.

NOTIFICATION: _____

I understand it is standard procedure of A Brighter Choice, to notify the legal representative of any serious incidents such as emergency room visits, hospitalization, abuse/neglect allegations etc., and to notify me during routine conversations of minor incidents such as minor behaviors, minor medication errors. This includes all incident reports both minor and critical unless otherwise indicated here:

RELEASE OF INFORMATION: _____

Permission is granted for A Brighter Choice, to share information with other service providers as required by the Supports for Community Living or Michelle P. Waiver.

Permission is also given for providers of other services such as medical, dental, etc., to discuss and/or release information to A Brighter Choice. Permission is given for A Brighter Choice, to provide information to medical and other service providers as required to facilitate continuity of care and to conduct normal routine business.

PHOTOGRAPHIC CONSENT: _____

I authorize A Brighter Choice, to maintain a photograph of me (or the participant I represent) as required by the Supports for Community Living or Michelle P. Waiver. I understand this photograph will not be used for any advertising purposes. It will be used strictly for identification purposes. The provider will contact me for additional approval in order to use photographs for any purpose other than to meet MPW/SCL requirements.

I understand I have freedom of choice with providers. I am aware I may choose one or more providers for services. I have been informed that no provider may require me or the participant I represent to receive all services from them, or to receive unwanted services in order to receive other services. I understand no provider can refuse services to me or the participant I represent based on my choice of other providers. Providers who violate the freedom of choice allowing the participants to choose their providers are at risk of being terminated as a Medicaid provider.

I understand A Brighter Choice, will assist me, the participant, and the case manager in my request regarding choice of providers, including giving information, assistance contacting service providers, and with the process of facilitating tours/meetings with these potential service providers. I understand I should contact my Case Manager if I wish to add or remove service providers at any time.

The participant, and/or my legal representative are aware of the freedoms available to the participant in the MPW/SCL waiver to choose service providers to provide covered services. I have been provided the resources where I can locate a list of current KY MPW/SCL providers at the time of this agreement.

PARTICIPANT RIGHTS
(Addendum to General Consents)

The participant rights as recognized by A Brighter Choice shall include:

1. The right to access accurate and easy-to-read information.
2. The right to be treated with dignity and respect and to maintain one's dignity and individuality.
3. The right to voice grievances and complaints regarding services and supports that are furnished, without fear of retaliation, discrimination, coercion, or reprisal.
4. The right to a choice of approved service provider(s).
5. The right to accept or refuse services.
6. The right to be informed of and participate in preparing the Person-Centered Plan of Care and any changes in the Plan of Care.
7. The right to be advised in advance of the provider(s) who will furnish services and the frequency and duration of services.
8. The right to confidential treatment of all information, including information in the participant's record(s).
9. The right to receive services in accordance with the current Person-Centered Plan of Care.
10. The right to be informed of the name, business, telephone number, and business address of the person supervising the services and how to contact the person.
11. The right to have property and residence treated with respect.
12. The right to be fully informed of any cost share liability and the consequences if any cost share is not paid.
13. The right to review the individual participant's records upon request.
14. The right to receive adequate and appropriate services without discrimination.
15. The right to be free from mental, verbal, sexual, and physical abuse, neglect, exploitation, isolation, corporal or unusual punishment, including interference with daily functions of living and educated on abuse, neglect, exploitation, isolation and any type of corporal or unusual punishment.
16. The right to be free from mechanical, chemical, or physical restraints.
17. The right to live and work in an integrated setting.
18. The right to time, space, and opportunity for personal privacy.
19. The right to communicate, associate, and meet privately with the person of choice.
20. The right to send and receive unopened mail.
21. The right to retain and use personal possessions, including clothing and personal articles.
22. The right to private, accessible use of a telephone or cell phone.

By signing below, I acknowledge that the above Rights have been reviewed and explained to me and that I understand these rights.

Participant: _____ Date_____

Legal Representative: _____ Date: _____

Provider Agency Name: _____

Agency Representative_____Date:_____

Other: _____ Date:_____

** I will be provided a copy of these signed consents upon request.
01/25/2023 EW