Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

HOME AND COMMUNITY BASED WAIVER SERVICES
SELECTION OF PROVIDER FORM

□ **Section I: HCB Waiver Member Demographics (Please print clearly)**

Name (Last, First, Middle): ______________________________

Date of Birth: (____ / ____ / ________) County of Residence: ____________________

Medicaid Identification Number (MAID): ________________________ (10 digits)

Street: ______________________________

City: ____________________ State: __________ Zip Code: ______________

Member's Telephone #: (______) ______________ Alternate Telephone #: (_____) ______________

Representative's Name & Telephone #: ______________________(_____) ______________

□ **Section II: Selection of Provider for Reassessment Service (Please print clearly)**

Current Reassessment Provider's Name & Telephone #: ______________________(_____) ______________

Agency's Name: ______________________________ Provider #: ______________________

I understand that I have the freedom to choose who will provide my HCB Waiver reassessment service. Effective ______ / _____ / ______, I select ______________________________ to provide my reassessment service. I further understand that I am required to update this provider selection form at any time I decide to select a new reassessment provider. I also understand that I have a right to receive a copy of this form and have it explained to me.

Selected Agency's Name: ______________________________Provider #: ______________________

Agency's address: ______________________________ Telephone #: (_____) ______________

□ **Section III: Selection of Provider for Case Management Services (Please print clearly)**

Current Case Manager's Name & Telephone #: ______________________(_____) ______________

Agency's Name: ______________________________ Provider #: ______________________

I understand that I have the freedom to choose who will provide my HCB Waiver case management services. Effective ______ / ______ / ______, I select ______________________________ to provide my case management services. I further understand that I am required to update this provider selection at any time I decide to select a new case management provider. I also understand that I have a right to receive a copy of this form and have it explained to me.

Selected Agency's Name: ______________________________Provider #: ______________________

Agency's address: ______________________________ Telephone #: (_____) ______________

□ **Section IV: Authorized Signatures**

- I have read the above information or had the information read to me and my questions were answered to my satisfaction.

Member's or Representative's Signature: ______________________________ Date: ______________

- As the **Current** Case Manager, I have fully explained the above information and have provided a copy of this form to the Member and/or the Member's Representative.

Case Manager's Signature: ______________________________ Date: ______________

Note: The current Case Manager must submit a copy of the MAP-23 to the PRO and to the selected provider(s) indicated above with every requested change and anytime the MAP 109-HCBW is completed/modified.

Clear Form