Map -2000
(Rev 07/08)

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

INITIATION/TERMINATION OF CONSUMER DIRECTED OPTION (CDO)

☐ **SCL**
☐ **MP**
☐ **HCB**
☐ **ABI**

Member Name: _____ Medicaid Member ID #: _____

Case Manager/Support Broker: _____ _____
(Name) (Phone)

Provider Number: _____

☐ Addition of CDO Services Date: _____ Initials: _____

I understand that I have the freedom to choose the Consumer Directed Option for some or all of my waiver services. This has been explained to me and I choose consumer directed services. In making this decision, I understand the following terms of the program:

I understand that I may:

- Train or arrange training for employees necessary for providing care.
- Ask for a change in my Plan of Care (POC)/Support Spending Plan (SSP) if I feel my needs have changed.
- Select a representative to help me with decisions about the CDO.
- Bring whomever I want to all meetings pertaining to the CDO.
- Complain or ask for a hearing if I have problems with my health care.
- Voluntarily dis-enroll from the CDO Program at any time and receive my services through the traditional waiver program.

I understand that I shall:

- Develop a POC/SSP to meet my needs within the Consumer Directed Options (CDO) according to program guidelines and my individual budget.
- Hire, supervise, and when necessary, fire my providers.
- Submit timesheets, paperwork required for my employees.
- Treat my providers and others that work for the CDO program the same way I want to be treated.
- Participate in the development of my POC/SSP and manage my individual budget.
- Complete all the paperwork necessary to participate in the CDO program, and follow all tax and labor laws,
- Be treated with respect and dignity and to have my privacy respected.
- Keep all my scheduled appointments.
- Pay my patient liability as determined by Department for Community Based Services (DCBS), failure to do so will result in termination from CDO.

*For addition of CDO services, attach revised MAP 109 Plan of Care.

Date traditional case management ends and Support Broker begins _____/_____/_____
Date traditional services end and CDO services begin: _____/_____/_____

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

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INITIATION/TERMINATION OF CONSUMER DIRECTED OPTION (CDO)

Member Name: _____ Medicaid Member ID #: _____

☐ Representative Designation Date: _____ Initials: _____

I appoint _____ as my representative for the Consumer Directed Option (CDO) Program.

_____
(Address)

_____ **KY**_____ _____
(City) (Zip) (Phone)

Relationship to Consumer: _____

My representative and I understand the following requirements

A CDO representative must:

- Be at least 21 years of age
- Not be paid for this role or for providing any other service to me
- Be responsible for assisting me in managing my care and individual budget
- Participate in training as directed by me and/or my support broker
- Have a strong personal commitment to me and know my preferences
- Have knowledge of me and be willing to learn about resources available in my community
- Be chosen by me

*For voluntary or involuntary termination of CDO service, attach revised MAP 109-Plan of Care.

☐ Voluntary Termination of CDO Services Date: _____ Initials: _____

I choose to terminate my services through the Consumer Directed Option and choose to receive my services through the traditional waiver program.

☐ Involuntary Termination of CDO Services
(To be completed by the Support Broker)

Reason for termination of CDO:
☐ Health and Safety Concerns
☐ Exceeding Individual Budget
☐ Inappropriate Utilization of Funds
☐ Other (Describe)

Traditional Provider Agency_____
Traditional Provider Number_____

_____ _____
Consumer/Guardian Signature Date

_____ _____
Representative Signature Date

_____ _____
Case Manager/Support Broker Signature Date

Clear Form