* The *Virginia Informed Choice (VIC) is required* for individuals who are newly enrolled or currently have a DD Waiver
* Retain a copy of the signed document in the individual’s file
* Review and complete the VIC with the individual and/or substitute decision-maker (SDM) at the following times:
	+ ***Annually***
* *At Enrollment into the Developmental Disability (DD) Waivers:*
	+ *Building Independence (BI)*
	+ *Family and Individual Supports (FIS)*
	+ *Community Living (CL)*
* *When there is a request for a change in waiver provider(s)*
* *When new services are requested*
* *When the individual wants to move to a new location and/or is dissatisfied with the current provider*
* *When making a Regional Support Team (RST) referral for individuals with a DD Waiver*
	+ *Submit the VIC with the RST Referral to the secure RST mailbox:* *RST.Referrals@DBHDS.virginia.gov*

|  |  |  |  |
| --- | --- | --- | --- |
| Date Completed: Enter date | Individual’s Name: Enter name | Substitute Decision Maker: Enter name  | **Choose Waiver:** Select one |

1. *Discuss each applicable HCBS service* ***prior to*** *assisting the individual with identifying Waiver service options*
2. *Confirm discussion of all applicable waiver service options by checking the options listed below*

|  |  |  |
| --- | --- | --- |
| ***Residential Options N/A*** [ ]  | ***Employment and Day Options N/A*** [ ]  | ***Additional Options N/A*** [ ]  |
| [ ]  Independent Living Supports *(BI Waiver Only)* | [ ]  Individual Supported Employment | [ ]  Peer Mentoring | [ ]  Community Guide |
| [ ]  Shared Living | [ ]  Group Supported Employment | [ ]  Assistive Technology | [ ]  Benefits Planning |
| [ ]  Supported Living | [ ]  Workplace Assistance Services | [ ]  Transition Services | [ ]  Support Coordination |
| [ ]  In-home Support Services | [ ]  Community Engagement | [ ]  Environmental Modifications |
| [ ]  Sponsored Residential | [ ]  Electronic Home-Based Services |
| [ ]  Group Home Residential 4 beds or less | [ ]  Community Coaching | [ ]  Employment and Community Transportation |
| [ ]  Group Home Residential 5 beds or more (RST req’d) | [ ]  Group Day Services | [ ]  Individual and Family/Caregiver Training *(FIS Waiver Only)* |
| ***Medical and Behavioral Support Options N/A*** [ ]  | ***Crisis Support Options N/A*** [ ]  | ***Agency-Directed*** [ ]  ***Consumer-Directed*** [ ]  ***N/A*** [ ]  |
| [ ]  Skilled Nursing *(FIS & CL Waivers Only)* | [ ]  Community-Based Crisis Supports | [ ]  Consumer-Directed Services Facilitation *(FIS & CL Only)*  |
| [ ]  Private Duty Nursing *(FIS & CL Waivers Only)* | [ ]  Center-Based Crisis Supports | [ ]  Personal Assistance Services *(FIS & CL Waivers Only)* |
| [ ]  Therapeutic Consultation *(FIS & CL Waivers Only)* | [ ]  Crisis Support Services | [ ]  Respite *(FIS & CL Waivers Only)* |
| [ ]  Personal Emergency Response System (PERS) |  | [ ]  Companion *(FIS & CL Waivers Only)* |
| SC has provided the opportunity to talk with other individuals receiving BI/FIS/CL Waiver services who live and work successfully in the community or with their family members Yes [ ]  No [ ]   | *You may contact a DBHDS Family Resource Consultant at (804) 894-0928 or (804) 201-3833 to connect with individuals and families who have waiver services* | *Provider options are available on the DBHDS Licensing website and the DBHDS Provider Survey* [*http://lpss.dbhds.virginia.gov/LPSS/LPSS.aspx*](http://lpss.dbhds.virginia.gov/LPSS/LPSS.aspx)[*http://ejiujiu0.wixsite.com/providersurvey*](http://ejiujiu0.wixsite.com/providersurvey) |

3. List multiple providers in each section if applicable and indicate option selected

 In making a decision, I/we considered the following Options:

| Options | Provider Agency, Location (City) and Bed Capacity | Option Selected | Reason(s) Selected/Denied (Be specific) |
| --- | --- | --- | --- |
| **Support Coordination** | Enter agency | SC Name/Agency | Enter reason |
| Select service | Enter provider information | Provider | Enter reason |
| Select service | Enter provider information | Provider | Enter reason |
| Select service | Enter provider information | Provider | Enter reason |
| Other | Enter provider information | Provider | Enter reason |
| Other | Enter provider information | Provider | Enter reason |
| Other | Enter provider information | Provider | Enter reason |

I may contact my Support Coordinator/Case Manager (SC/CM) to seek assistance with resolving provider-related issues. I have the option of changing providers, including my SC/CM. I have the right to a fair hearing and appeal process. I may be responsible for some service cost (patient pay), based on my income. If I chose Consumer-Directed Services, I am responsible for employing my own personal assistants and know there are services in the BI/FIS/CL Waivers that require a backup plan if there is a lapse in services. I will actively participate in the development of my Person-Centered Individual Support Plan.

**My SC/CM discussed the above information with me.**

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Individual Signature/Date SDM Signature (if applicable)/Date SC/CM Signature/Date

Regional Support Team referral is REQUIRED if any of the following criteria apply: Community: Select one Training Center: Select one