**ACKNOWLEDGEMENT OF SERVICES OPTIONS AND CLIENT SELECTIONS**

This Acknowledgment relates to the receipt of Home and Community Based (**HCBS**) Waiver and Alternative Care (**AC**) services from providers that are selected by you.

If Dakota County staff or a case manager under contract to Dakota County has given me this form, I understand that I am or may become eligible to receive **HCBS** or **AC** services. Service providers must enroll with the Minnesota Department of Human Services to provide those services. If a service provider meets the requirements as determined by the State, I understand that I may choose to receive services from that provider if the services offered are consistent with my care plan. The State of Minnesota **HCBS** and **AC** services provider system requires that I have the right to choose which providers I will receive services from. I acknowledge that Dakota County staff cannot make these choices for me, and that they cannot substitute their own judgment for the determination made by the Minnesota Department of Human Services that a specific provider is qualified to provide the **HCBS** and **AC** services that the provider offers.

I understand that Dakota County staff or a case manager under contract with Dakota County may assist me in reviewing and identifying enrolled providers that offer services that address my needs and preferences. The case manager will confirm whether a provider I want to select is currently enrolled with the Minnesota Department of Human Services. I also understand that I must select the specific providers that I will receive these services from. Therefore, I understand that I, and not Dakota County or its agents, am selecting the **HCBS** and **AC** service providers that I will use and that the State of Minnesota, and not Dakota County, has determined whether those providers are qualified to provide the services they offer.

I also acknowledge that any comments and other information provided to me by Dakota County staff or case managers under contract with Dakota County related to specific providers that I select and the specific services each offers:

* is not an endorsement or verification of the effectiveness or competence of the providers;
* is not a guarantee or representation that a provider I select is the most appropriate or most effective provider for the services that I may require under my specific circumstances; and
* that Dakota County disclaims any liability for the adequacy of the **HCSB** and **AC** services that I receive from my selected providers.

Participant’s Name (printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian’s Name (printed) if needed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Or

Parent or Guardian’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_