Innovations Waiver / Freedom of Choice

The NC Innovations Waiver allows individuals with I/DD to receive services and supports in their community helping them live as independently as possible rather than in an institution like a developmental center.

Member information

1

First name: _____ Last name: _____

Date of birth (mm/dd/yyyy): _____

Alliance Claims System (ACS) ID: ☐☐☐☐☐☐

Medicaid ID: _____

ISP start date (mm/dd/yyyy): _____

Authorization

2

I understand that enrollment in the NC Innovations Waiver is strictly voluntary. I also understand that if I am determined to be ICF-IID eligible, I will be receiving waiver services instead of services in an ICF-IID (intermediate care facility for individuals with intellectual disabilities). I understand that in order to be determined to need waiver services, an individual must require the provision of **at least one waiver service monthly** and that failure to use a waiver service monthly will jeopardize my continued eligibility for the Innovations waiver.

◯ I **have chosen** NC Innovations Waiver services

◯ I **have not chosen** NC Innovations Waiver services

Name:* _____

Signature of individual or legally responsible person* Date (mm/dd/yyyy)*

x		

Submission instructions

Completed forms should be emailed to MedCSlotManage@AllianceHealthPlan.org.