NC Traumatic Brain Injury Waiver / Freedom of Choice

This form is for the member or their legally responsible person to indicate whether or not they choose TBI Waiver services.

Member information

1

Member's name: _____ Record number: _____

Medicaid ID: _____

Authorization

2

I understand that enrollment in the TBI Waiver is strictly voluntary. I also understand that if enrolled I will be receiving Waiver services instead of services in a Skilled Nursing or Acute Rehabilitation Facility. 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 TBI Waiver.

- ○ I **have chosen** TBI Waiver services
- ○ I **have not chosen** TBI Waiver services

Signature of individual or legally responsible person (type name or print and sign)*	Date (mm/dd/yyyy)*
x	

Submission instructions

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