

Survey of Interest in Home and Community Based Waivers

Name of Individual: _____

Medicaid Number: _____

Date Survey Completed: _____

If the response is from a legal guardian or parent of a minor, complete the following information:

Legal Guardian's Name: _____

Legal Guardian's Address: _____

Legal Guardian's Telephone Number: () _____

Note: If you are responding as the guardian, the term 'you' in the survey refers to the person for whom you are responsible.

1. If your needs can be met and the opportunity is available, would you like to explore the option of moving from your current home to a home and community based waiver setting within the next two years?

YES ___ NO ___ I Don't Know ___

2. If you do not want to move within the next two years, do you think you would like to move from your current home to a home and community based waiver setting anytime after two years?

YES ___ NO ___ I Don't Know ___

3. If you answered Question 1 or 2, above, as "I Don't Know" would you like additional information about home and community based waiver options?

YES ___ NO ___

The completed survey may be mailed in the attached, self-addressed envelope or can be found at www.mrrdd.ohio.gov, on the Department of MR/DD homepage in the center section labeled Martin v Taft and returned on-line. If mailing, return the survey to:

Ohio Department of MR/DD Attention: Survey
1810 Sullivant Avenue
Columbus, Ohio 43224

Please return this response no later than April 30, 2007