MARYLAND
Department of Health and Mental Hygiene
Office of Health Care Financing

Agreement to Waive Nurse Monitoring

Office of Health Services: Community Options Division

By signing this agreement, I _____ (participant name), choose to self-direct and monitor my own personal assistance services by waiving the frequency of nurse monitoring services being recommended by my Local Health Department.

By waiving nurse monitoring recommendations, I accept full responsibility for my personal assistance provider(s) and agree to:

- Inform my personal assistance provider of my personal assistance needs;
- Instruct my personal assistance provider on how to perform duties related to my activities of daily living, instrumental activities of daily living and other health-related needs;
- Accept two contacts, in person or by phone, from a nurse monitor annually unless otherwise requested;
- Notify my supports planner if I wish to resume using the nurse monitoring service; and
- Make my supports planner aware of any issues that may impact my health and safety.

I understand that, by signing below, I will assume all liability associated with my decision to request to waive program requirements and knowingly release the Department, and the local health department that provides the nurse monitoring service, from all liability arising from my request to waive these requirements.

Participant Signature: _____ Date: _____

Witness Signature: _____ Date: _____