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

Agreement to Waive Supports Planning

Office of Health Services: Community Options Division

By signing this agreement, I _____ (participant name), choose to self-direct all services by waiving the following activities offered by a supports planner (please check all that apply):

	Activity	*By waiving this activity, I agree to:*
	Monthly Contact	• *Follow the Department's Reportable Events policy for any incident related to your services.* • *Contact my supports planning agency when necessary.*
	Quarterly Visit	• *Follow the Department's Reportable Events policy for any incident related to your services.* • *Contact my supports planning agency when necessary.*
	Plan of Service Development, Revisions and Submission	• *Review the Department's Plan of Service Development Manual;* • *Develop a Plan of Service that meets the Department's guidelines and receive approval from the Department before receiving services.* • *Utilize the Department's Client Portal to upload and/or submit all pertinent documentation required.*

I understand that I will select a Supports Planning Agency, regardless of the activities waived above, and that they will contact me annually to ensure completion of my application to receive Medicaid services under the waiver or State Plan program. I acknowledge that I may contact my selected supports planning agency at any time. However, the supports planning agency will not visit me unless I request it.

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 from all liability arising from my request to waive these requirements.

Participant Signature: _____ Date: _____

As the supports planner, I agree to complete all administrative tasks related to the provision of this service required under the Supports Planning Agency solicitation with the exception of the activities waived within this signed document.

Supports Planner Signature: _____ Date: _____