Services My Way
Enrollment Form

Name of Participant: _____

Medicaid #:_____SS#:_____DOB:_____

Date of Enrollment/start of budget: _____

Name of Representative (If Necessary):_____

☐ If participant selects a representative, SMW Designation for Authorized Representative form must be completed

I understand that I have the freedom to choose the Services My Way (SMW) service model for some or all of my waiver services. This has been explained to me and I choose to direct my own services. In making this decision, I understand the following terms of the service model:

I understand that I may:

- Train or arrange training for my employees
- Ask for a change in my individual service plan, budget or spending plan if I feel my needs have changed
- Select a representative to help me with decisions about my services
- Appeal any decision made if I have problems with my services
- Voluntarily withdraw from Services My Way at any time and receive my services through the traditional waiver program

I understand that I shall:

- Be treated with dignity, courtesy, consideration and respect at all times
- Have my privacy respected at all times
- Treat all of my employees with dignity, courtesy, consideration and respect at all times
- Develop a service plan to meet my needs within the Services My Way guidelines and my individual budget
- Manage my employees
  - Decide whom to hire
  - Decide what special knowledge or skills my employee must possess
  - Replace workers who do not meet my needs
- Act as an employer
  - Determine employee wages and work schedules
  - Review and submit timesheets
  - Complete all the necessary paperwork required for my employees
  - Follow all tax and labor laws
- Participate in the development of my service plan, individual budget and individual spending plan
- Keep all my scheduled appointments

Date traditional services end and SMW begin: ____/____/____

_____	_____
Participant Signature	Date
_____	_____
Representative Signature	Date
_____	_____
Care Manager/Service Coordinator Signature	Date