TEXAS
Health and Human Services

Form H1700-3
August 2021-E

Individual Service Plan – Signature Page

Individual Service Plan Begin Date:	Individual Service Plan End Date:	Revision Date:
Applicant/Member Name:	Applicant/Member Medicaid ID No. or Social Security No.:	

Freedom of Choice: I understand that the STAR+PLUS Home and Community Based Services (HCBS) program is a feasible alternative to nursing facility services. I have been informed of the nature and limitations of the program and I freely choose services through the STAR+PLUS HCBS program.

Acknowledgement and Acceptance of the Individual Service Plan: I, the applicant, member or authorized representative, acknowledge review of the waiver services identified on Form H1700-1, Individual Service Plan. I also acknowledge review of the program items/services identified on Form H1700-2, Individual Service Plan - Addendum, and accept the plan as appropriate to meet the medical, functional and cognitive needs assessed. I understand the state of Texas will not pay for the services on the plan until all eligibility decisions are made and waiver services are authorized by Texas Health and Human Services Commission.

Applicant/Member or Authorized Representative:

Printed Name	Signature	Date

Witness: *(if applicable)*

Printed Name	Signature	Date

Service Coordinator Verification: I verify the applicant or member was assessed to establish or maintain eligibility for the STAR+PLUS HCBS program. Medical need and rationale were established on Form H1700-2, Individual Service Plan – Addendum, and the waiver services identified are necessary and appropriate to meet the needs of the applicant or member in the community.

Service Coordinator:

Printed Name	Signature	Date