NORTH Dakota | Health & Human Services
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# 1915(i) Plan of Care Member and Care Coordinator Signatures & Acknowledgements

## Member Acknowledgment

I have helped create or review and update my Person-Centered Plan of Care and participated to the best of my ability. I agree with what is written in my plan. I was told of my right to be free of abuse, neglect, exploitation, and the use of restraints. My care coordinator has given me information on my rights and responsibilities. I understand my rights and/or have someone I trust who can help me understand them. If applicable, I agree to the settings modifications specified in this plan. I understand that my plan will be reviewed every three months and that I can ask for it to be reviewed sooner. I was given a choice of services and providers and understand I have the right to request a change in services or providers at any time. This plan can be shared as necessary to provide my services. I give permission for my insurance information to be submitted for billing purposes as needed. I know to talk to my care coordinator if I want to change my services or what is in my Person-Centered Plan of Care

### Member Signature

Member Printed Name _____

Member Signature _____ Date _____

Parent or Legal Guardian Printed Name _____

Parent or Legal Guardian Signature _____ Date _____

## Care Coordinator Attestation

I attest this member's plan of care was developed or reviewed and updated with the above listed member and in accordance with 1915(i) policies and procedures.

### Care Coordinator Signature

Care Coordinator Printed Name _____

Care Coordinator Signature _____ Date _____