

**Community First Choice/Personal Assistance Service  
RISK NEGOTIATION FORM**

Date: \_\_\_\_\_

Member: \_\_\_\_\_ Medicaid ID # \_\_\_\_\_

Name of person and agency completing this form:

\_\_\_\_\_

**Section 1:** Description of the member's choices or preferences that can be a potential risk to the member's health and welfare:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 2:** Description of the potential consequences of the risks to the member:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 3:** Description of formal or informal support services that can be provided that might assist member in mitigating the risk:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 4:** Description of the member's decisions/plans regarding choices/preferences that can be a risk to him/her:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 5:**

- Support service options (including nursing home services) have been explained to the member.
- The member understands and accepts the risks associated with his/her current CFC service plan.
- The member does not have a guardian and has not been declared incapacitated.
- The member's health and welfare cannot be assured and discharge from CFC will be implemented.

**Section 6:** If the member opts to receive services in a manner that is inconsistent with health and safety the signatures below must be gathered prior to service plan implementation.

\_\_\_\_\_  
Member/PR Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Plan Facilitator Signature (when applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Regional Program Officer Signature

\_\_\_\_\_  
Date