

New Jersey Department of Human Services
Division of Aging Services
P. O. Box 807
Trenton, NJ 08625-0807

OPTIONS COUNSELING ATTESTATION STATEMENT

Date: _____

I have been advised that the options selected in the Consumer Planning Worksheet are for informational purposes only and are not a guarantee of service. I have been further advised that many publicly funded programs have varying financial and clinical eligibility requirements. If applicable, I have been directed to contact the County Welfare Agency (CWA) to determine my Medicaid financial eligibility.

Name of Consumer (Print): _____

Signature of Consumer: _____

Signature of Family or Legal Representative (if present): _____

The options selected in the Consumer Planning Worksheet have been discussed with this consumer as potential service options. I have not implied or guaranteed delivery of these services.

Name of Options Counselor (Print): _____

Signature of Options Counselor: _____

Date of Options Counseling Session: _____

Please list all individuals present at time of assessment / options counseling session:
