

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, *et al.*, §
Plaintiffs §

v. §

RICK PERRY, Governor of the State of Texas, §
et al., §
Defendants §

Case No. 5:10-CV-1025-OG

THE UNITED STATES OF AMERICA, §
Plaintiff-Intervenor §

v. §

THE STATE OF TEXAS §
Defendant §

DECLARATION OF STACY LINDSEY

1. “My name is Stacy Lindsey, and I am over 18 years of age, of sound mind, and capable of making this declaration. The facts stated in this declaration are true and correct and are within my personal knowledge due to my personal involvement, or are within my personal knowledge based on a review of DADS records, as described herein.

2. “I am currently employed with the Texas Department of Aging and Disability Services (“DADS”) as manager of the Local Procedure Development and Support unit within the Local Authority Section of the Access and Intake Division. As unit manager, my responsibilities include authorizing the release of program vacancies for the Home and Community-based Services (HCS) and Texas Home Living Medicaid waiver programs, overseeing the tracking of the progress of enrollments in the program, and managing the HCS interest list. Prior to being manager, I worked in the same unit and was responsible for tracking the progress of

enrollments in the HCS and Texas Home Living programs and managed the HCS interest list. My work and professional experience has made me familiar with the policies, procedures, programs, and practices of DADS relating to enrollment in the HCS Medicaid waiver program.

3. “In August 2012, Patricia Ferrer, Zakowitz Morgan, Eric Steward, Andrea Padron, and Linda Arizpe, five of the plaintiffs in this lawsuit, were informed by their respective local mental retardation authorities (“local authorities”), that “diversion slots” were available in the HCS Medicaid waiver program. To be offered an HCS diversion slot, an individual must first submit an application packet to the State Supported Living Center program and be found eligible for admission to a State Supported Living Center. All five of these individuals or their legal guardians decided to pursue this opportunity. With the assistance of their local authorities, each individual followed the procedures to apply for admission to a State Supported Living Center and requested access to the HCS program as an alternative to admission to a State Supported Living Center.

4. “Following that process, each of the five individuals was offered a slot in the HCS program on September 14, 2012. Since September 14, each individual or the individual’s guardian has signed the Verification of Freedom of Choice accepting the HCS program (true and correct copies of which are attached hereto as Exhibits A through E), and has been working with his or her local authority to choose an HCS provider and go through the necessary steps to enroll in the HCS program. Typically, the enrollment process takes less than 90 days. In the case of the five plaintiffs, however, advocates with Disability Rights Texas have arranged for physical therapy evaluations and other kinds of evaluations to be done for most of these individuals before they visit prospective providers for pre-placement visits. This may cause some delays in the enrollment process.

Patricia Ferrer

5. “Patricia Ferrer made two pre-placement visits to Family Faith HCS provider and later selected that provider. Ms. Ferrer is scheduled to meet with a representative from Family Faith and the local authority enrollment service coordinator on November 13, 2012 to complete the enrollment process. Ms. Ferrer is scheduled to move on November 19th.

Zakowitz Morgan

6. “Zakowitz Morgan and his guardian are interviewing potential providers. They visited one provider but Mr. Morgan was unable to access the group home because the home was not wheelchair accessible. The local authority enrollment service coordinator is working with Mr. Morgan and his guardian to ensure future potential providers are aware of Mr. Morgan’s accessibility needs.

Eric Steward

7. “At the request of the attorney for Disability Rights Texas, a physical therapy evaluation was completed for Eric Steward. A conference call with the attorney, the local authority staff, and Mr. Steward and his mother was scheduled for November 9, 2012, to discuss the results of the evaluation as well as the HCS services to be included on Mr. Steward’s Individual Plan of Care. Mr. Steward and his mother are still in the process of selecting a provider with the assistance of their advocate.

Andrea Padron

8. “At the request of the attorney for Disability Rights Texas, a physical therapy evaluation was completed for Andrea Padron. A conference call with the attorney, the local authority staff, and Ms. Padron’s guardian was scheduled for November 9, 2012, to discuss the results of the evaluation as well as the HCS services to be included on Ms. Padron’s Individual

Plan of Care. Ms. Padron's guardian is still in the process of selecting a provider with the assistance of an advocate.

Linda Arizpe

9. "The attorney for Disability Rights Texas requested a physical therapy evaluation be completed for Linda Arizpe. The recommendations from the evaluation will be used to develop Ms Arizpe's Individual Plan of Care at the enrollment meeting scheduled for November 14, 2012. Ms. Arizpe's mother is her legal guardian. Her guardian has selected Caleb, Inc., as the HCS provider. Ms. Arizpe's mother and father have chosen to self-direct the supported home living and respite that will be provided through the HCS waiver. The Consumer Directed Service Agency that Ms. Arizpe's guardian has selected to provide financial management services is Imagine Enterprises. Ms. Arizpe will be moving to her parents' home at Canyon Lake, where she is scheduled to begin receiving HCS services on December 1, 2012.

"I hereby declare under penalty of perjury that the foregoing is true and correct."

Executed on November 12, 2012.

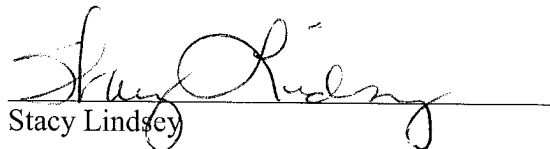

Stacy Lindsey

Exhibit A

Waiver Program/Programa opcional
Verification of Freedom of Choice/Verificación de libre opción

Name of Individual/Nombre de la persona <i>Patricia Ferrer</i>	CARE ID/Núm. de identificación (HCS and TxHmL Only)	Medicaid No./Núm. de Medicaid
Address (Street, City, State, ZIP Code)/Dirección (calle, ciudad, estado y código postal)		

As a recipient or potential recipient of Medicaid funded services, I understand that I have a choice between the waiver program I have selected and the applicable institutional program from which it is waived.

Como beneficiario o posible beneficiario de servicios financiados por medio de Medicaid, entiendo que tengo una opción entre el programa opcional que he seleccionado y el programa institucional que me hubiera correspondido.

I have been informed of the services available through the waiver program I have selected. The services I would receive through this waiver program will be identified on my service plan.

Me han informado de los servicios disponibles por medio del programa opcional que he seleccionado. Los servicios que recibiría bajo este programa opcional estarán indicados en mi plan de servicios.

I have received information about the types of institutional services available to me.

He recibido información sobre los tipos de servicios institucionales que puedo recibir.

Providing that I meet the eligibility requirements, I have been given the choice of either institutional or home and community-based services and I choose the following:

Siempre y cuando yo llene los requisitos de elegibilidad, me han dado la opción de seleccionar entre servicios institucionales y de apoyo en el hogar y en la comunidad, y escojo el siguiente:

- Community Living Assistance and Support Services (CLASS)
- Consolidated Waiver Program (CWP)
- Deaf Blind with Multiple Disabilities (DBMD)
- Home and Community-based Services (HCS) Program
- Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) Institutional Program
- Nursing Facility (NF) Institutional Program
- Texas Home Living (TxHmL) Program
- Other: _____

- Servicios de Apoyo y Asistencia para Vivir en la Comunidad (CLASS)
- Programa Opcional Combinado (CWP)
- Programa Opcional de Personas Sordociegas con Discapacidades Múltiples (DBMD)
- Programa de Servicios en el Hogar y en la Comunidad (HCS)
- Programa institucional de Centros de atención intermedia para personas con una discapacidad intelectual o un padecimiento relacionado (ICF/IID)
- Programa institucional de Centros para Convalecientes (NF)
- Programa de Texas para Vivir en Casa (TxHmL)
- Otro: _____

for the following reason: _____

por las siguientes razones: _____

Patricia Ferrer
Signature - Individual/Legally Authorized Representative
Firma de la persona o del representante legalmente autorizado

09/21/12
Date/Fecha

[Signature]
Signature - Agency Representative
Firma del representante del departamento

9/21/12
Date/Fecha

Metrocare
Agency Name
Nombre del departamento

309
Comp Code (HCS and TxHmL Only)

M

Exhibit B

Waiver Program/Programa opcional
Verification of Freedom of Choice
 Verificación de libre opción

Name of Individual/Nombre de la persona Zakowitz Morgan		
Address (Street, City, State, ZIP Code) [Redacted] Calle, ciudad, estado y código postal	CARE ID/Núm. de Identificación (HCS and TxHmL Only) [Redacted]	Medicaid No./Núm. de Medicaid [Redacted]

As a recipient or potential recipient of Medicaid funded services, I understand that I have a choice between the waiver program I have selected and the applicable institutional program from which it is waived.

Como beneficiario o posible beneficiario de servicios financiados por medio de Medicaid, entiendo que tengo una opción entre el programa opcional que he seleccionado y el programa institucional que me hubiera correspondido.

I have been informed of the services available through the waiver program I have selected. The services I would receive through this waiver program will be identified on my service plan.

Me han informado de los servicios disponibles por medio del programa opcional que he seleccionado. Los servicios que recibiría bajo este programa opcional estarán indicados en mi plan de servicios.

I have received information about the types of institutional services available to me.

He recibido información sobre los tipos de servicios institucionales que puedo recibir.

Providing that I meet the eligibility requirements, I have been given the choice of either institutional or home and community-based services and I choose the following:

Siempre y cuando yo llene los requisitos de elegibilidad, me han dado la opción de seleccionar entre servicios institucionales y de apoyo en el hogar y en la comunidad, y escojo el siguiente:

- Community Living Assistance and Support Services (CLASS)
- Consolidated Waiver Program (CWP)
- Deaf-Blind with Multiple Disabilities (DBMD)
- Home and Community-based Services (HCS) Program
- Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Institutional Program
- Nursing Facility (NF) Institutional Program
- Texas Home Living (TxHmL) Program
- Other: _____

- Servicios de Apoyo y Asistencia para Vivir en la Comunidad (CLASS)
- Programa Opcional Combinado (CWP)
- Programa Opcional de Personas Sordociegas con Discapacidades Múltiples (DBMD)
- Programa de Servicios en el Hogar y en la Comunidad (HCS)
- Programa institucional de Centros de Atención Intermedia para Personas con Retraso Mental (ICF/MR)
- Programa institucional de Centros para Convalecientes (NF)
- Programa de Texas para Vivir en Casa (TxHmL)
- Otro: _____

for the following reason: _____

por las siguientes razones: _____

Sharon Barker as Guardian
 Signature - Individual/Legally Authorized Representative
 Firma de la persona o del representante legalmente autorizado

9/24/12
 Date/Fecha

Erica Phillips, COS Liaison
 Signature - Agency Representative
 Firma del representante del departamento

9/24/2012
 Date/Fecha

MHMRA of Harris County
 Agency Name
 Nombre del departamento

280
 Comp Code (HCS and TxHmL Only)

Exhibit C

Waiver Program/Programa opcional
Verification of Freedom of Choice/Verificación de libre opción

Name of Individual/Nombre de la persona: ERIC STEWARD
CARE ID/Núm. de identificación: [redacted]
Medicaid No./Núm. de Medicaid: [redacted]
Address (Street, City, State, ZIP Code)/Dirección (calle, ciudad, estado y código postal): [redacted]

As a recipient or potential recipient of Medicaid funded services, I understand that I have a choice between the waiver program I have selected and the applicable institutional program from which it is waived.

Como beneficiario o posible beneficiario de servicios financiados por medio de Medicaid, entiendo que tengo una opción entre el programa opcional que he seleccionado y el programa institucional que me hubiera correspondido.

I have been informed of the services available through the waiver program I have selected. The services I would receive through this waiver program will be identified on my service plan.

Me han informado de los servicios disponibles por medio del programa opcional que he seleccionado. Los servicios que recibiría bajo este programa opcional estarán indicados en mi plan de servicios.

I have received information about the types of institutional services available to me.

He recibido información sobre los tipos de servicios institucionales que puedo recibir.

Providing that I meet the eligibility requirements, I have been given the choice of either institutional or home and community-based services and I choose the following:

Siempre y cuando yo llene los requisitos de elegibilidad, me han dado la opción de seleccionar entre servicios institucionales y de apoyo en el hogar y en la comunidad, y escojo el siguiente:

- Community Living Assistance and Support Services (CLASS)
Consolidated Waiver Program (CWP)
Deaf Blind with Multiple Disabilities (DBMD)
[X] Home and Community-based Services (HCS) Program
Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) Institutional Program
Nursing Facility (NF) Institutional Program
Texas Home Living (TxHmL) Program
Other:

- Servicios de Apoyo y Asistencia para Vivir en la Comunidad (CLASS)
Programa Opcional Combinado (CWP)
Programa Opcional de Personas Sordociegas con Discapacidades Múltiples (DBMD)
Programa de Servicios en el Hogar y en la Comunidad (HCS)
Programa institucional de Centros de atención intermedia para personas con una discapacidad intelectual o un padecimiento relacionado (ICF/IID)
Programa institucional de Centros para Convalecientes (NF)
Programa de Texas para Vivir en Casa (TxHmL)
Otro:

for the following reason:

por las siguientes razones:

Signature - Individual/Legally Authorized Representative
Firma de la persona o del representante legalmente autorizado

Date/Fecha: 10/8/12

Signature - Agency Representative
Firma del representante del departamento

Date/Fecha: 10/8/12

Agency Name: Alamo Local Authority
Nombre del departamento

Comp Code (HCS and TxHmL Only): 051

Exhibit D

Waiver Program/Programa opcional
Verification of Freedom of Choice/Verificación de libre opción

Name of Individual/Nombre de la persona <i>Andrea Padron</i>	CARE ID/Núm. de identificación (HCS and TxHmL Only)	Medicaid No./Núm. de Medicaid
Address (Street, City, State, ZIP Code)/Dirección		

As a recipient or potential recipient of Medicaid funded services, I understand that I have a choice between the waiver program I have selected and the applicable institutional program from which it is waived.

Como beneficiario o posible beneficiario de servicios financiados por medio de Medicaid, entiendo que tengo una opción entre el programa opcional que he seleccionado y el programa institucional que me hubiera correspondido.

I have been informed of the services available through the waiver program I have selected. The services I would receive through this waiver program will be identified on my service plan.

Me han informado de los servicios disponibles por medio del programa opcional que he seleccionado. Los servicios que recibiría bajo este programa opcional estarán indicados en mi plan de servicios.

I have received information about the types of institutional services available to me.

He recibido información sobre los tipos de servicios institucionales que puedo recibir.

Providing that I meet the eligibility requirements, I have been given the choice of either institutional or home and community-based services and I choose the following:

Siempre y cuando yo llene los requisitos de elegibilidad, me han dado la opción de seleccionar entre servicios institucionales y de apoyo en el hogar y en la comunidad, y escojo el siguiente:

- Community Living Assistance and Support Services (CLASS)
- Consolidated Waiver Program (CWP)
- Deaf Blind with Multiple Disabilities (DBMD)
- Home and Community-based Services (HCS) Program
- Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) Institutional Program
- Nursing Facility (NF) Institutional Program
- Texas Home Living (TxHmL) Program
- Other: _____

- Servicios de Apoyo y Asistencia para Vivir en la Comunidad (CLASS)
- Programa Opcional Combinado (CWP)
- Programa Opcional de Personas Sordociegas con Discapacidades Múltiples (DBMD)
- Programa de Servicios en el Hogar y en la Comunidad (HCS)
- Programa institucional de Centros de atención intermedia para personas con una discapacidad intelectual o un padecimiento relacionado (ICF/IID)
- Programa institucional de Centros para Convalecientes (NF)
- Programa de Texas para Vivir en Casa (TxHmL)
- Otro: _____

for the following reason: _____

por las siguientes razones: _____

Ron Hudecek
Signature - Individual/Legally Authorized Representative
Firma de la persona o del representante legalmente autorizado

10/10/12
Date/Fecha

[Signature]
Signature - Agency Representative
Firma del representante del departamento

10/10/12
Date/Fecha

Alamo Local Authority
Agency Name
Nombre del departamento

057
Comp Code (HCS and TxHmL Only)

Exhibit E

Texas Department of Aging and Disability Services

Form 8601
September 2012

Waiver Program/Programa opcional
Verification of Freedom of Choice/Verificación de libre opción

Name of Individual/Nombre de la persona <u>LINDA DABIZDE</u>	CARE ID/Núm. de identificación [REDACTED] <small>(HCS and TxHML Only)</small>	Medicaid No./Núm. de Medicaid [REDACTED]
Address (Street, City, State, ZIP Code)/Dirección (calle, ciudad, estado y código postal) [REDACTED]		

As a recipient or potential recipient of Medicaid funded services, I understand that I have a choice between the waiver program I have selected and the applicable institutional program from which it is waived.

Como beneficiario o posible beneficiario de servicios financiados por medio de Medicaid, entiendo que tengo una opción entre el programa opcional que he seleccionado y el programa institucional que me hubiera correspondido.

I have been informed of the services available through the waiver program I have selected. The services I would receive through this waiver program will be identified on my service plan.

Me han informado de los servicios disponibles por medio del programa opcional que he seleccionado. Los servicios que recibiría bajo este programa opcional estarán indicados en mi plan de servicios.

I have received information about the types of institutional services available to me.

He recibido información sobre los tipos de servicios institucionales que puedo recibir.

Providing that I meet the eligibility requirements, I have been given the choice of either institutional or home and community-based services and I choose the following:

Siempre y cuando yo llene los requisitos de elegibilidad, me han dado la opción de seleccionar entre servicios institucionales y de apoyo en el hogar y en la comunidad, y escojo el siguiente:

Community Living Assistance and Support Services (CLASS)

Servicios de Apoyo y Asistencia para Vivir en la Comunidad (CLASS)

Consolidated Waiver Program (CWP)

Programa Opcional Combinado (CWP)

Deaf Blind with Multiple Disabilities (DBMD)

Programa Opcional de Personas Sordociegas con Discapacidades Múltiples (DBMD)

Home and Community-based Services (HCS) Program

Programa de Servicios en el Hogar y en la Comunidad (HCS)

Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) Institutional Program

Programa institucional de Centros de atención intermedia para personas con una discapacidad intelectual o un padecimiento relacionado (ICF/IID)

Nursing Facility (NF) Institutional Program

Programa institucional de Centros para Convalecientes (NF)

Texas Home Living (TxHML) Program

Programa de Texas para Vivir en Casa (TxHML)

Other: _____

Otro: _____

for the following reason: _____

por las siguientes razones: _____

Alvina D. Greipe
Signature – Individual/Legally Authorized Representative
Firma de la persona o del representante legalmente autorizado

9/27/12
Date/Fecha

Linda Burgess
Signature – Agency Representative
Firma del representante del departamento

9/27/12
Date/Fecha

Hill County MHSOC
Agency Name
Nombre del departamento

470
Comp Code (HCS and TxHML Only)