

# FREEDOM OF CHOICE

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Representative (if any): \_\_\_\_\_

## SECTION I – FUNCTIONAL/MEDICAL ELIGIBILITY

Based on an assessment of functional abilities and needs conducted on \_\_\_\_\_, the applicant indicated above: (date)

- Does** meet the functional/medical eligibility criteria for Medicaid LTC programs by scoring in Door \_\_\_\_\_.
- Does Not** meet the functional/medical eligibility criteria for Medicaid NF Level of Care (please proceed to Section III)

\_\_\_\_\_  
Signature of professional completing assessment Title Date

## SECTION II - FREEDOM OF CHOICE

I have been advised that I meet functional/medical eligibility and choose to receive services and supports under the following program:

- MI Choice Program. I have received local referral information.

Local Referrals: \_\_\_\_\_  
\_\_\_\_\_

- Nursing facility care. I have received information about nursing facilities in my area.
- PACE Program. I have received information about the PACE program.

\_\_\_\_\_  
Signature of applicant Signature of applicant's representative Date

## SECTION III - APPEAL RIGHTS

I have received a copy of a denial of service based on this determination and understand my right to appeal.

\_\_\_\_\_  
Signature of applicant Signature of applicant's representative Date