

MI CHOICE WAIVER ENROLLMENT NOTIFICATION

INSTRUCTIONS

This form must be used by MI Choice waiver agencies to notify local Michigan Department of Health and Human Services (MDHHS) offices of MI Choice participant enrollment dates, as well as subsequent changes made to MI Choice enrollment dates.

General Instructions

- Waiver agencies must notify MDHHS of a MI Choice enrollment date within five business days of the enrollment, using the MI Choice Waiver Enrollment Notification form.
- When the waiver agency needs to change a previously reported MI Choice start date, the waiver agency must send written updates to the local MDHHS office using the enrollment form, with the new date and the reason for altering the original date.
- Waiver agencies must notify MDHHS at least annually of a participant's continued MI Choice enrollment using the MI Choice Enrollment Notification form. This notification may coincide with the annual Medicaid redetermination date, but could occur at any time during the year. The purpose of this notification is to assure that MDHHS knows the participant remains eligible for and is enrolled in the program.
- Waiver agencies retain the original enrollment forms in the participant's record for a minimum of six years and send a copy of each form to MDHHS.

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN
SERVICES**

**MI CHOICE WAIVER ENROLLMENT
NOTIFICATION**

Waiver Agency Name (Select One):

Medicaid Provider ID Number:

Phone Number:
() -

Fax Number:
() -

Contact Person:

Participant Information

First Name:			Last Name:		
Address (Number & St., Apt., etc):			Check if address has changed: Yes: ☐ No: ☐		Medicaid ID Number:
City:	State:	ZIP:	Phone Number: () -		

Enrollment Information:

MI Choice Enrollment/LOC 22 Start Date: _____

Urgent Request: ☐ Yes ☐ No

* Urgent request is selected when not having the appropriate Level of Care status significantly impacts the participant's immediate availability to medically necessary services.

Reason for Enrollment (Check Appropriate Reason)				
☐	New Assessment	Date of Assessment:		
☐	Nursing Home Discharge	Date of Discharge:		
☐	Nursing Home Information	Name:		
		Address (Number & St., Apt., etc.):	City:	State: ZIP:
☐	Ended Home Help	Date Home Help Ended:		
☐	Re-enrollment			
☐	Other (Explain):			

I certify that the information above is true, accurate, and complete to the best of my knowledge.

Signature of Waiver Agency Representative

Date

MDHHS County Office (Select One):

None Selected

District

Number: _____

Date of MDHHS Office Notification:

Method of MDHHS submission (check): ☐ Email ☐ Fax ☐ Phone Call ☐ Dropped off at MDHHS office

Other: _____

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.