

FREEDOM OF CHOICE

Home and Community-Based Services Waiver for the Elderly and Disabled

Section 1 - To be Completed by PARTICIPANT or REPRESENTATIVE:

Beneficiary Name (Last, First, Middle Initial)			Social Security Number	MIhealth I.D. Number
Beneficiary's Address (Number and Street, etc.)			Birth Date (MMDDYYYY) / /	County
City	State	ZIP Code	Beneficiary Phone Number ()	
Does this Person Live in a Nursing Care Facility? <input type="checkbox"/> NO <input type="checkbox"/> YES 			If YES, enter the Name of that Facility	

I, the Undersigned, have had the recommendations as shown below explained to me. I understand the options available to me. I choose the following option and hold harmless the provider from any liability resulting in my decision.

- I ACCEPT and APPROVE the Recommendations Below**
- I REJECT the Recommendations Below**
- I Wish to APPEAL the Recommendation and Request the Opportunity for a Fair Hearing**
- I have Received a Copy of the Appeal Process**

Participant / Legal Representative Signature	Date	Witness to Signature	Date
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Section 2 - To be Completed by Organized Health Care Delivery System (OHCDS):

OHCDS PROVIDER Name (Last, First, Middle Initial)			<i>for Provider Use</i>	
Provider Address (Number and Street, etc.)			Provider NPI Number	
City	State	ZIP Code	Provider Phone Number ()	
Type of Assessment <input type="checkbox"/> INITIAL <input type="checkbox"/> RE - ASSESSMENT 			Date of Assessment	

Based on the needs identified through the assessment, the provider recommends the following: **(CHECK ONLY ONE)**

- COMMUNITY BASED CARE** as developed and coordinated by the provider.
The plan of care will be developed with participant review and approval and approval of all providers.
- NURSING CARE FACILITY** based on the identified needs for extensive 24-hour care / supervision.
The Provider will assist in placement based on the needs of the participant.

The above Recommendation is made on this Date	Signature of Provider
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AUTHORITY: Title XIX of the Social Security Act

The Department of Community Health is an equal opportunity employer, services, and programs provider

COMPLETION: Is VOLUNTARY