Michigan Department of Health and Human Services
Children's Special Health Care Services
Children with Medical Complexity Targeted Case Management
(CMC TCM)
Informed Consent Form

This form provides consent to enroll in the Children with Medical Complexity Targeted Case Management (CMC TCM) program at (insert program name). This form will be kept as part of your medical record. Please type or print all requested information.

Beneficiary Information

Beneficiary's Name (Last, First, Middle):	
Date of Birth:	CSHCS/Medicaid ID:
Address:	
Phone Number:	
Email Address:	

Parent/Guardian Information

Parent/Guardian Name (Last, First, Middle):	
Date of Birth:	Phone Number:
Address:	
Email Address:	

By enrolling in the CMC TCM program, I agree to:

- Maintain enrollment in the CSHCS and/or Medicaid program.
- Participate in a comprehensive assessment and individualized plan of care.
- Maintain contact with the CMC TCM core team while receiving services.
- Participate in appointments, referrals, and other TCM program services.
- Give consent for the CMC TCM team to share medical information with other healthcare providers.

By signing this form, I understand that:

- Enrollment in the CMC TCM program is voluntary, and I can disenroll at any time.
- While enrolled in the CMC TCM program, I may not receive TCM services from other State of Michigan TCM programs.
- Eligibility and access to other necessary medical services will not be impacted if I choose to decline or terminate services.
- I may be disenrolled from the CMC TCM program for the following reasons:
    - I do not receive a CMC TCM service within a three-month period;
    - I turn 21 years of age;
    - I become ineligible for Medicaid and/or CSHCS enrollment ends;
    - I transition into hospice;
    - I move out of state;
    - I fail to participate in a comprehensive assessment and/or development of a comprehensive individualized plan of care; or
    - If I comment fraud, abuse, or misconduct.
- If I am disenrolled from the CMC TCM program, I will need to reapply to resume CMC TCM services.
- I have the right to appeal any decision regarding my eligibility for the CMC TCM program. Also, appeal information will be provided upon any change in eligibility or upon request.

By signing this form, I confirm that:

- I have received information about the CMC TCM program and other programs which provide this service.
- I have been provided a CMC TCM point of contact and had an intake meeting.

Client Signature:	Date (MM-DD-YYYY)
☐I acknowledge that the child named in this form is too young or unable to sign on their behalf. Guardianship documents are required for beneficiaries over 18.	

Parent/Guardian Signature:	Date (MM-DD-YYYY)

Please return the completed form to the program staff for signature.

CMC TCM Physician Signature:	Date (MM-DD-YYYY)
By signing this form, I acknowledge that the client is eligible for the CMC TCM program and has been accepted into the program at (Provider to insert program name). I also acknowledge that the client and their family have reviewed this form with the client and our team has answered any questions. A copy of this consent form must be maintained within the client record at all times.	

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.
AUTHORITY: Title XIX of the Social Security Act and Administrative rule 400.1104(a) COMPLETION: Is voluntary, but is required if Medical Assistance program payment is desired.