MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 14-26

Distribution: Medicaid Home and Community Based Services Waiver for the Elderly and Persons with a Disability (MI Choice), Nursing Facilities, County Medical Care Facilities, Hospital Long Term Care Units, Hospital Swing Beds, Ventilator Dependent Care Units, Centers for Independent Living, Private Duty Nursing

Issued: July 1, 2014

Subject: MI Choice Chapter Revisions

Effective: As Indicated

Programs Affected: Medicaid

The purpose of this bulletin is to describe the changes being made to the MI Choice Chapter in the Medicaid Provider Manual. These changes reflect revisions made in the section 1915(c) MI Choice waiver renewal application and the addition of the section 1915(b) MI Choice waiver initial application, both approved by the Centers for Medicare and Medicaid Services (CMS) on September 25, 2013.

The following section changes have been added to the MI Choice Chapter of the Medicaid Provider Manual and are effective October 1, 2013:

General Information

The waiver is approved by CMS under section 1915(c) and section 1915(b) of the Social Security Act. The Michigan Department of Community Health (MDCH) carries out its waiver obligations through a network of enrolled providers that operate as Prepaid Ambulatory Health Plans (PAHPs). These entities are commonly referred to as waiver agencies. In the past, waiver agencies operated as Organized Health Care Delivery Systems (OHCDS).

Eligibility

To initiate financial eligibility determination, waiver agencies must use MI Choice Waiver Enrollment Notification (MSA-0814) form to notify the Michigan Department of Human Services (DHS) of individuals who have applied for MI Choice. MI Choice Waiver Disenrollment Notification (MSA-0815) form must be used by waiver agencies to notify DHS of participants who no longer qualify for MI Choice enrollment.

MI Choice no longer uses a case status classification system to determine reassessments for participants. Reassessments for all participants are conducted in person 90 days after the initial assessment, with a reassessment each subsequent 180 days, or sooner upon a significant change in the participant's condition.

Enrollment

MI Choice applicants require at least two waiver services on a continual basis, one of which must be Supports Coordination, in order to be enrolled in MI Choice. Per CMS requirements, MDCH reviews and provides final approval for determinations that result in enrollment, denials or terminations for MI Choice.

Services

Supports Coordination and Nursing Services have been added to MI Choice as new services, and Homemaker, Personal Care, and Residential Services have been combined into Community Living Supports. These services are detailed below. Criteria for Private Duty Nursing (PDN) have been expanded and are also detailed below. Nursing Facility Transition Services has been renamed Community Transition Services.

Medication administration in MI Choice is established through the provisions of Nursing Services.

Supports Coordination

Supports Coordination is provided to assure the provision of supports and services required to meet the participant's health and welfare needs in a home and community-based setting. Without these supports and services, the participant would otherwise require institutionalization. The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the participant's plan of service. The frequency and scope of supports coordination contacts must take into consideration health and safety needs of the participant. Supports Coordination does not include the direct provision of other Medicaid services.

Supports coordinators perform the following functions:

1. Conduct the initial and subsequent Nursing Facility LOCD per state policy. Refer to the Functional Eligibility subsection for additional information.
2. Conduct the initial Resident Assessment Instrument -- Home Care assessment and periodic reassessments.
3. Facilitate a person-centered planning process that is focused on the participant's preferences, includes family and other allies as determined by the participant, identifies the participant's goals, preferences and needs, provides information about options, and engages the participant in monitoring and evaluating services and supports.
4. Assist the participant with developing a plan of service using the person-centered planning process, including revisions to the plan of service at the participant's initiation or as changes in the participant's circumstances may warrant.
5. Referral to and coordination with providers of services and supports, including non-Medicaid services and informal supports. This may include providing assistance with access to entitlements or access to legal representation.
6. Monitor MI Choice waiver services and other services and supports necessary for achievement of the participant's goals. Monitoring includes opportunities for the participant to evaluate the quality of services received and whether those services achieved desired outcomes. This activity includes the participant and other key sources of information as determined by the participant.
7. Provide social and emotional support to the participant and allies to facilitate life adjustments and reinforce the participant's sources of support. This may include arranging services to meet those needs.
8. Provide advocacy in support of the participant's access to program benefits, assuring rights as a program participant and supporting the participant's decisions.
9. Maintain documentation of the above listed activities to ensure successful support of the participant, comply with Medicaid and other applicable policies, and meet the performance requirements delineated in the waiver agency's contract with MDCH.

Additional guidance on Supports Coordination is located in the contract between MDCH and MI Choice waiver agencies, which is available online. (Refer to the Directory Appendix for website information). In addition to requiring and accepting Supports Coordination services, applicants must also require and agree to accept one additional MI Choice service, which is needed by the applicant every 30 calendar days in order to qualify for the program.

Community Living Supports

Community Living Supports facilitate an individual's independence and promote participation in the community. Community Living Supports can be provided in the participant's residence or in community settings. Community Living Supports include assistance to enable participants to accomplish tasks that they would normally do for

themselves if able. The services may be provided on an episodic or a continuing basis. The participant oversees and supervises individual providers on an on-going basis when participating in self-determination options. Tasks related to ensuring safe access and egress to the residence are authorized only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. When transportation incidental to the provision of community living supports is included, it shall not also be authorized as a separate waiver service for the participant. Transportation to medical appointments is covered by Medicaid through DHS.

Community Living Supports includes:

1. Assisting, reminding, cueing, observing, guiding and/or training in household activities, activities of daily living or routine household care and maintenance.
2. Reminding, cueing, observing and/or monitoring of medication administration.
3. Assistance, support and/or guidance with such activities as:
    a. Non-medical care (not requiring nurse or physician intervention) – assistance with eating, bathing, dressing, personal hygiene, and activities of daily living,
    b. Meal preparation, but does not include the cost of the meals themselves,
    c. Money management,
    d. Shopping for food and other necessities of daily living,
    e. Social participation, relationship maintenance and building community connections to reduce personal isolation,
    f. Training and/or assistance on activities that promote community participation, such as using public transportation, using libraries, or volunteer work,
    g. Transportation (excluding to and from medical appointments) from the participant's residence to community activities, among community activities, and from the community activities back to the participant's residence, and
    h. Routine household cleaning and maintenance
4. Dementia care, including but not limited to redirection, reminding, modeling, socialization activities, and activities that assist the participant as identified in the individual's person-centered plan.
5. Staff assistance with preserving the health and safety of the individual in order that he/she may reside and be supported in the most integrated independent community setting.
6. Observing and reporting any change in the participant's condition and the home environment to the supports coordinator.

These service needs differ in scope, nature, supervision arrangements or provider type (including provider training and qualifications) from services available in the State Plan. The differences between the waiver coverage and the State Plan are that the provider qualifications and training requirements are more stringent for community living supports tasks as provided under the waiver than the requirements for these types of services under the State Plan.

Community Living Support services cannot be provided in circumstances where they would be a duplication of services available under the State Plan or elsewhere. The distinction must be apparent by unique hours and units in the approved service plan.

Nursing Services

Nursing Services are covered on an intermittent (separated intervals of time) basis for a participant who requires nursing services for the management of a chronic illness or physical disorder in the participant's home. These services are provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the direct supervision of an RN. Nursing Services are for participants who require more periodic or intermittent nursing than available through the Medicaid State Plan or third party payer resources for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the participant such as hospitalizations and nursing facility admissions. MI Choice Nursing Services shall not duplicate services available through the Medicaid State Plan or third payer resources.

When the participant's condition is unstable, could easily deteriorate, or significantly changes, MI Choice covers nurse visits for observation and evaluation. The purpose of the observation and evaluation is to monitor the participant's condition and report findings to the participant's physician or other appropriate health care professional to prevent additional decline, illness, or injury to the participant. The supports coordinator shall communicate with both the nurse providing this service and the participant's health care professional to assure the nursing needs of the participant are being addressed.

Participants must meet at least one of the following criteria to qualify for this service:

- Be at high risk of developing skin ulcers, or have a history of resolved skin ulcers that could easily redevelop,
- Require professional monitoring of vital signs when changes may indicate the need for modifications to the medication regimen,
- Require professional monitoring or oversight of blood sugar levels, including participant-recorded blood sugar levels, to assist with effective pre-diabetes or diabetes management,
- Require professional assessment of the participant's cognitive status or alertness and orientation to encourage optimal cognitive status and mental function or identify the need for modifications to the medication regimen,
- Require professional evaluation of the participant's success with a prescribed exercise routine to assure its effectiveness and identify the need for additional instruction or modifications when necessary,
- Require professional evaluation of the participant's physical status to encourage optimal functioning and discourage adverse outcomes, or
- Have a condition that is unstable, could easily deteriorate, or experience significant changes AND a lack of competent informal supports able to readily report life-threatening changes to the participant's physician or other health care professional.

In addition to the observation and evaluation, a nursing visit may also include, but is not limited to, one or more of the following nursing services:

- Administering prescribed medications that cannot be self-administered, as defined under Michigan Complied Law (MCL) 333.7103(1),
- Setting up medications according to physician orders,
- Monitoring participant's adherence to their medication regimen,
- Applying dressings that require prescribed medications and aseptic techniques, and
- Providing refresher training to the participant or informal caregivers to assure the use of proper techniques for health-related tasks such as diet, exercise regimens, body positioning, taking medications according to physician's orders, proper use of medical equipment, performing activities of daily living, or safe ambulation within the home.

This service is limited to no more than two hours per visit. Participants receiving PDN services are not eligible to receive MI Choice Nursing Services.

Private Duty Nursing

PDN services are skilled nursing interventions provided to a participant age 21 and older on an individual and continuous basis to meet health needs directly related to the participant's physical disorder. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the participant's plan of service. To be eligible for PDN services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III.

The participant's plan of service must provide reasonable assurance of participant safety. This includes a strategy for effective back-up in the event of an absence of providers. The back-up strategy must include informal supports or the participant's capacity to manage his or her care and summon assistance.

PDN for a participant between the ages of 18-21 is covered under the Medicaid State Plan.

Medical Criteria I – The participant is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:

- Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate-dependent respiration (e.g., some models of bi-level positive airway pressure), or
- Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period, or
- Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility, or
- Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility, or
- Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below.

Medical Criteria II – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments, or interventions (as described in III below) as a result of a substantiated medical condition directly related to the physical disorder.

Definitions of Medical Criteria II:

- "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months.
- "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.
- "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.
- "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- "Directly related to the physical disorder" means an illness, diagnosis, physical impairment, or syndrome that is likely to continue indefinitely, and results in significant functional limitations in 3 or more activities of daily living.
- "Substantiated" means documented in the clinical or medical record, including the nursing notes.

Medical Criteria III – The participant requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.

Definitions of Medical Criteria III:

- "Continuous" means at least once every 3 hours throughout a 24-hour period, and when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.
- Equipment needs alone do not create the need for skilled nursing services.

- "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to:

    - Performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions,
    - Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the participant four or more hours per day,
    - Deep oral (past the tonsils) or tracheostomy suctioning,
    - Injections when there is a regular or predicted schedule, or prn injections that are required at least once per month (insulin administration is not considered a skilled nursing intervention),
    - Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility,
    - Total parenteral nutrition delivered via a central line and care of the central line,
    - Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below, and
    - Monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.

Participants receiving MI Choice Nursing Services are not eligible to receive PDN Services.

- Where applicable, the participant must use Medicaid State Plan, Medicare, or third party payers first.
- The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.
- It is not the intent of the MI Choice program to provide PDN services on a continual 24 hours per day, 7 days per week basis. MI Choice services are intended to supplement informal support services available to the participant. Only under extreme circumstances should 24/7 PDN be authorized for a participant. These circumstances must be clearly described in the participant's case record and approved by MDCH.
- 24/7 PDN services cannot be authorized for participants who cannot direct their own services and supports, make informed decisions for themselves, or engage their emergency back-up plan without assistance. These participants must have informal caregivers actively involved in providing some level of direct services to them on a routine basis.
- All PDN services authorized must be medically necessary as indicated through the MI Choice assessment and meet the medical criteria set forth in this chapter.
- PDN services must be ordered by the participant's physician, physician's assistant, or nurse practitioner. These healthcare professionals must work in conjunction with the waiver agency and the provider agency to assure PDN services are delivered in accordance with their respective order.

Nursing Facility Transitions

Transition Services

For the contract period, MDCH will reimburse the waiver agency for prudent and allowable transition expenses and supports coordination costs in accordance with Nursing Facility Transition Guidelines. As specified in the contract between MDCH and the waiver agency, the waiver agency must notify MDCH of its intention to transition a nursing facility resident to the MI Choice program when initiating a nursing facility transition plan. Procedures for notification are obtained from the MI Choice program contract manager. The waiver agency must demonstrate

the nursing facility resident has a Medicaid application pending with DHS or has been approved for Medicaid and meets MI Choice program criteria. Once the participant is enrolled in the MI Choice program, MDCH will issue payment to the waiver agency for Community Transition Services. Non-waiver nursing facility transition funding is available for those who do not enroll in the MI Choice program upon transition, or do not transition.

Administration

Waiting List Reporting

Waiting list data is collected and maintained on a secure, web-based application. Waiver agencies must complete all required fields for each qualified MI Choice applicant. Waiting list data must be entered online within one business day after completion of the Telephone Intake Guidelines. If an applicant is removed from the MI Choice waiting list, the data must be completed online within five business days and include the reason for removal.

Financing and Reimbursement

MDCH is no longer using a fee-for-service reimbursement model for MI Choice. Waiver agencies are paid through capitation payments and are required to submit all encounter data to MDCH. Encounter data is processed through the Community Health Automated Medicaid Processing System (CHAMPS). Waiver agencies are required to submit all financial reports as detailed in the annual contract.

Reimbursement Schedule

MDCH no longer uses the Supports Coordination and Operations Reimbursement (SCORE) model to reimburse waiver agencies. At the end of each month, MDCH will run the 834 Enrollment file for each waiver agency. This file contains an electronic listing of individuals who are enrolled in the MI Choice program with each provider. The Medicaid Management Information System then performs quality checks including: verification of current Medicaid eligibility; a valid LOCD indicating the participant meets nursing facility level of care; and the participant is not enrolled in any other long term care program. On the fourth pay cycle of each month, the 820 premium payment will run and will electronically transfer the appropriate per member per month capitation payment for each participant enrolled with each waiver agency.

Special Services

MDCH no longer allows special financing structures under the capitation model. Gap-filling services and Temporarily Ineligible Participant (TIP) services remain a part of the MI Choice service structure. Gap-filling services and TIP services must be included in encounter data submitted to MDCH. TIP services for any given participant are limited to a cumulative total of no more three months per calendar year unless prior approval is obtained from MDCH.

Encounter Data Reporting

Each waiver agency must submit all encounter data to MDCH within 180 calendar days of the date that services were rendered. Under the prior fee-for-service model, waiver agencies had 365 calendar days to submit claims data to MDCH.

Administrative Expense and Other Financial Reporting

Each waiver agency shall submit an Administrative Expense Report (AER) to MDCH as specified in the contract in place of the Financial Status Report. The expenses reported must be actual expenses incurred by the waiver agency. Each AER shall cover one calendar month and is due within 30 calendar days after the conclusion of that month. Cost reconciliation is obsolete.

Providers

Under the section 1915(b) waiver, providers may no longer subcontract directly with MDCH. All providers must subcontract with waiver agencies.

Enrollment of Service Providers

To assure network capacity as well as choice of providers, each waiver agency must have a provider network with capacity to service at least 125% of their monthly slot utilization for each MI Choice service, and at least two providers for each MI Choice service. When waiver agencies cannot assure this choice within 30 miles or 30 minutes travel time for each enrollee, they may request a rural area exception from MDCH.

Use of Restraints, Seclusion or Restrictive Interventions

Providers are prohibited from using seclusion or restrictive interventions in addition to using restraints. Qualified reviewers conduct Clinical Quality Assurance Reviews and home visits, which include a discovery process to examine the use of restraints, seclusion or restrictive interventions by family or caregivers. Supports coordinators have the primary responsibility for identifying and addressing the use of restraints, seclusion or restrictive interventions.

Program Quality

Types of Critical Incidents and Serious Events

New critical incidents or events that now must be reported to MDCH include medication errors and restraints, seclusion or restrictive interventions.

Critical Incident Reporting

Waiver agencies are responsible under contract for tracking and responding to individual critical incidents using the Critical Incident Reporting web-based system. Waiver agencies are required to report the type of critical incidents, the responses to those incidents, and the outcome and resolution of each event within 30 days of the date of knowledge of the incident. The online system allows MDCH to review the reports in real time and ask questions or address concerns with the waiver agencies. MDCH must receive notification from waiver agencies of suspicious deaths within two business days.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
Medical Services Administration

Michigan Department of Community Health

MI CHOICE WAIVER ENROLLMENT NOTIFICATION

INSTRUCTIONS

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

General Instructions

- Waiver agencies must notify DHS 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 DHS office using the enrollment form, with the new date and the reason for altering the original date.

- Waiver agencies must notify DHS 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 DHS 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 DHS.

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

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

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**

DHS County Office (Select One): None Selected District Number: _____

Date of DHS Office Notification: _____

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

Other: _____

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

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Michigan Department of Community Health

MI CHOICE WAIVER DISENROLLMENT NOTIFICATION

INSTRUCTIONS

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

General Instructions

- Waiver agencies must notify local DHS offices in writing within five business days of participant disenrollment from MI Choice. The MI Choice end date is the last day of the participant's enrollment in MI Choice.

- When the waiver agency needs to change a previously reported MI Choice disenrollment date, the waiver agency sends written updates to the local DHS office on a disenrollment form, with the new date and the reason for altering the original date.

- 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 DHS.

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

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

MI CHOICE WAIVER DISENROLLMENT NOTIFICATION

Waiver Agency Name (Select One):	
Medicaid Provider ID Number:	
Phone Number: ( ) -	Fax Number: ( ) -
Contact Person:	

Participant Information

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

Disenrollment Information

MI Choice Stop/LOC 22 End Date: _____

Reason for Disenrollment: (Check Applicable Reason)				
☐ Death	Date of Death:			
☐ Nursing Home Placement	Date of Admission:			
☐ Nursing Home Information	Name:			
	Address (Number & St., Apt., etc.):	City:	State:	ZIP:
☐ No longer Eligible for MI Choice	Reason:			
☐ Enrolled in Home Help	Date of Enrollment:			
☐ Moved New Address:	Address (Number & St., Apt., etc.):	City:	State:	ZIP:
☐ 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**

DHS County Office (Select One): None Selected District Number: _____

Date of DHS Office Notification: _____

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

Other: _____

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

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