**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**

**MI HEALTH LINK HCBS WAIVER APPLICATION AND CONSENT/ELIGIBILITY CERTIFICATION FORM**

**PRIORITY PROCESSING:**  Nursing Facility Transition  At imminent risk of nursing home admission

**SECTION 1**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Initial Certification** | | **Annual Recertification** | | **Next Recertification Due Date:** | |
| Last Name | | First Name | Medicaid # ***MUST be 10-digits – include leading zeros*** | | Date Of Birth |
|  | |  |  | |  |
| Address | | | City | | Zip |
|  | | |  | |  |
| Type of Residence: Private (home, apt., condo, etc.), Michigan licensed Adult Foster Care or Home for the Aged, unlicensed assisted living, other (describe) | | | Integrated Care Organization (ICO) | | ICO Contracted Waiver Entity (if applicable) |
| # Of Licensed Beds At Residence | DHS License # For Residence (If Applicable) | |  | | Self-Determination Arrangement (Y/N) |
|  |  | |  | |  |

This is to certify that the above named individual is eligible for Medicaid and Medicare coverage and has received a comprehensive evaluation of his/her needs. The comprehensive evaluation and supporting documentation are available in the individual’s record.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

ICO Care Coordinator/LTSS Supports Coordinator Signature & Credentials Date

**SECTION 2**

Based on the results of the comprehensive evaluation and supporting documentation, the following Waiver eligibility requirements are met:

The individual meets nursing facility level of care as evidenced by the Michigan Medicaid Nursing Facility Level of Care Determination tool.

This individual has a need for at least one of the MI Health Link HCBS waiver services.

**WAIVER RECOMMENDED**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

ICO Care Coordinator/LTSS Supports Coordinator Signature & Credentials Date

**SECTION 3**

I understand that I may accept or reject waiver services instead of services provided in a nursing facility and that I may withdraw this consent at any time in writing. This consent may not exceed 36 months or disenrollment from the MI Health Link HCBS waiver, whichever is sooner. I  **accept**  **reject** services as offered under the MI Health Link HCBS waiver.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Self  Legal Guardian/Legally Responsible Person

Signature Date  Telephone Consent Obtained (attach written consent)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness (required only if signature above made by a mark) Date

**FOR MDCH USE ONLY**

**SECTION 4**

**WAIVER ENROLLMENT:**

**ENROLLED**  or  **RECERTIFIED** **EFFECTIVE DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NOT ELIGIBLE** or  **DISENROLLED REASON: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If Disenrolled, Notice of Denial: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MDCH Signature Date