UPCAP Long-Term Care Programs
Self Determination Program Enrollment Agreement

Participant Name:_____ Date Of Birth:_____

SSN:_____ Medicaid ID #: _____

Program: ☐ MI Choice ☐ Care Management ☐ Veterans ☐ MI Health Link

Start Date of Budget: _____

I have reviewed the materials provided to me by UPCAP explaining the Self Determination Program, my responsibilities in directing my care, UPCAP'S responsibilities to me, the role of the Fiscal Intermediary (FI) and the Agency with Choice (AWC). I have decided to participate in this program.

**I have chosen the ☐ FI ☐ AWC option to manage my employees.

Representative Description

A representative may be a guardian, a family member or other supporter who willingly accepts the participant's responsibilities in directing their services and supports.

☐ I do not wish to designate a representative.

☐ I will designate a representative. I name the following person as my representative:

Name:_____

Address:_____

Phone: _____

I understand that enrollment into this program is voluntary and that I have a right to withdraw any time I choose.

Participant: _____Date:_____

Designated Representative: _____Date:_____

Supports Coordinator: _____ Date:_____