**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