SAMPLE
PRINT ON OFFICE LETTERHEAD

Date

RE: Mi-Choice Waiver Participant

Name:

DOB:

Attached is the assistance application for a potential Mi-Choice Waiver participant. This participant was assessed on {Date} and found medically eligible for services. Please process the attached application for Medicaid for enrollment into the Mi-Choice Waiver program.

If you have any questions, please feel free to call at

.

Sincerely,

Supports Coordinator

Enclosure(s)

* Signed consent and authorization