INITIAL ASSET ASSESSMENT
CONFIRMATION OF MI CHOICE WAIVER APPROVAL

MI Choice Waiver Agency Information:

Waiver Agency Name:	UPCAP Services, Inc
Street Address:	
City, State, Zip:	
Waiver Agency Provider ID #:	7059424
Contact Person:	
Contact Person Phone Number:	
Contact Person Email Address:	

Applicant Information:

Name:	
Street Address:	
City, State, Zip:	
Medicaid Beneficiary ID (if known):	
MI Choice Assessment Date:	

To Whom It May Concern:

The applicant named above has been assessed, determined medically eligible and approved for the MI Choice Waiver Program as of the MI Choice assessment date indicated above.

According to BEM 106, APPROVED for the waiver means:

- The waiver agency conducted the assessment, **and**
- There is an available waiver slot for the individual's placement, **and**
- A waiver agent has developed a person-centered plan of service, **and**
- The participant has already received appropriate waiver services for more than 30 consecutive days **or** is currently receiving appropriate waiver services that are expected to continue more than 30 consecutive days **or** expects to receive appropriate waiver services from the agent for at least 30 consecutive days.

Please process the applicant's Initial Asset Assessment to establish the individual's 30 days of continuous care period.

☐ The Initial Asset Assessment **is** attached to this notification.
☐ The Initial Asset Assessment **is not** attached to this notification.

This notification serves only to inform the MDHHS Local Office that the applicant has been approved for the MI Choice Waiver. The waiver agency will follow established procedures to notify the MDHHS Local Office of the applicant's MI Choice enrollment date.

Sincerely,

_____ _____

(Signature of Waiver Agency Representative) (Date)