UPCAP SERVICES, INC

MI CHOICE WAIVER ENROLLMENT NOTIFICATION

Waiver Agency Name (Select One):	UPCAP
Medicaid Provider ID Number:	7059424
Phone Number: ( ) -	Fax Number: ( ) -
Contact Person:	

Participant Information

First Name:			Last Name:	
Address (Number & St., Apt., etc):			Check if address has changed: **Yes:** ☐ **No:** ☐	Medicaid ID Number:
City:	State:	ZIP:	Phone Number: ( ) -	

Enrollment Information:

MI Choice Enrollment/LOC 22 Start Date: _____

Participant Medicaid Status: **Active Medicaid with Benefit Plan:** ☐

Medicaid with Spend-down: ☐ **Confirmed Income and Assets:** ☐

No Medicaid Benefit Plan: ☐ **Date Application Filed with MDHHS:**

Reason for Enrollment (Check Appropriate Reason)				
☐ New Assessment	Date of Assessment:			
☐ Nursing Home Discharge	Date of Discharge:			
☐ Nursing Home Information	Name:			
	Address (Number & St., Apt., etc.):	City:	State:	ZIP:
☐ Ended Home Help	Date Home Help Ended:			
☐ Re-enrollment				
☐ Other (Explain):				

I certify that the information above is true, accurate, and complete to the best of my knowledge.

_____ _____

Signature of Supports Coordinator **Date**

UPCAP Staff Notified:

Date of Notification: _____

Method of Notification: ☐ Email ☐ Fax ☐ Other: _____