

ANNUAL ENROLLMENT AGREEMENT

MEDICAID-FUNDED HCBS PASSPORT or ASSISTED LIVING WAIVER PROGRAM

I _____ wish to continue my enrollment in the PASSPORT or Assisted Living Waiver program and continue to receive home and community-based services in my home, community, or an Assisted Living facility as an alternative to receiving services in a nursing home or hospital setting. I acknowledge my obligation to comply with the following requirements of the Medicaid-Funded PASSPORT or Assisted Living HCBS Waiver Program:

Based upon my available income and resources I am/may be required to pay a monthly client liability toward the cost of any Medicaid-funded HCBS PASSPORT or Assisted Living services that I receive.

CDJFS has determined my monthly client liability to be: \$_____ per month as of _____ (date).

The Medicaid-Funded HCBS PASSPORT or Assisted Living waiver program offers me free choice of any approved ODA-Certified provider.

I must use all other available payer sources, including but not limited to: private health insurance, Medicare, and Medicaid state plan services, to acquire services before waiver services are authorized.

I must actively participate in the process of maintaining /verifying my Medicaid eligibility.

I will make myself available to meet with my case manager on a regular basis.

The services offered to me through this program will be delivered according to my service plan, which defines the types of services I will be receiving, service dates, and amounts of service.

My service plan will be reviewed with me on a regular basis.

My service plan will be monitored, reviewed by my case manager and is subject to change, as appropriate. I will contact my case manager if I need to discuss any changes to my service plan, or if there is any change to my health status or need.

I must assist in the development of an appropriate and reliable back-up plan for services if a provider is unable to furnish the agreed-upon service as directed in my service plan.

I must participate in an annual in-person assessment to determine my eligibility for continued enrollment in the Medicaid-funded waiver program.

I must immediately notify my case manager if authorized services are not provided or if I have any concerns or problems with a service provider. My case manager may be contacted by calling _____

I must immediately report any concerns, problems, events, change in health status (improvement or decline), injuries, change in informal support systems or other events that may affect my overall health and welfare to my case manager.

I may not ask a provider to furnish a service in violation of any rule, law, or ethical standards.

(SIGN ON BACK)

Consumer's Signature:	Date:
Consumer's Address:	
Authorized Representative Signature: (if present or if Consumer is unable to sign) Date:	
This form has been explained to the Consumer and/or Authorized Representative and a copy provided.	
Assessor or Case Manager Signature:	Date:

DISTRIBUTION: ORIGINAL TO PAA, COPY TO CONSUMER

ODA FORM 1044 (03/2014)