ENROLLMENT AGREEMENT

STATE-FUNDED PROGRAM ACKNOWLEDGEMENT:
I have been informed of the state-funded PASSPORT or Assisted living program options. I understand that enrollment is strictly voluntary and that, if approved, I will be receiving state-funded Home and Community Based Services (HCBS) until my financial eligibility to receive waiver-funded HBCS has been determined by a county department of job and family services. I also understand that the State-Funded Program is not an option if I have been determined by the County Department of Job and Family Services (CDJFS) to be either financially eligible or ineligible for HCBS Waiver program.

PASSPORT

- ☐ I choose to enroll in the state-funded program until my eligibility for enrollment in the Medicaid-funded component of PASSPORT HCBS has been determined by the CDJFS, but not to exceed three months. *I understand that if I am denied enrollment, I may request to appeal that decision.*

- ☐ I choose not to enroll in the state-funded component of the PASSPORT HCBS program at this time and acknowledge I may re-apply in the future.

Assisted Living

- ☐ I choose to enroll in the state-funded component of the Assisted Living HCBS waiver program until my eligibility for enrollment in the Medicaid-funded component of Assisted Living HCBS waiver has been determined by the CDJFS, but not to exceed three months. *I understand that if I am denied enrollment, I may request to appeal that decision.*

- ☐ I choose not to enroll in the state-funded component of the Assisted Living HCBS program at this time and acknowledge I may re-apply in the future.

MEDICAID-FUNDED PROGRAM ACKNOWLEDGMENT:
I understand that enrollment is strictly voluntary and that, if approved, I will be receiving Medicaid-funded Home and Community Based Waiver Services (HCBS) instead of receiving services in a nursing home or hospital.

PASSPORT

- ☐ I choose to enroll in the Medicaid-funded PASSPORT HCBS waiver program.

- ☐ I choose not to enroll in the Medicaid-funded PASSPORT HCBS waiver program at this time and acknowledge I may re-apply in the future.

Assisted Living

- ☐ I choose to enroll in the Medicaid-funded Assisted Living HCBS waiver program.

- ☐ I choose not to enroll in the Medicaid-funded Assisted Living HCBS waiver program at this time and acknowledge I may re-apply in the future.

PARTICIPANT RESPONSIBILITIES:
I acknowledge and agree the State-Funded Program or the HCBS Waiver Program delivers services as a cost-effective alternative to a nursing home or hospital.

I acknowledge and agree my enrollment in the State-Funded program may not exceed three months:
Last date of state-funded enrollment: _________________ ☐ N/A

I acknowledge and agree my enrollment in the State-Funded program may be terminated prior to three months if I no longer meet the non-financial eligibility criteria OR the Medicaid financial determination has been issued by the County Department of Job and Family Services. ☐ N/A

I acknowledge and agree I may be required to pay a monthly patient liability toward the cost of state-funded or Medicaid-funded HCBS services furnished:

PAA estimated monthly patient liability for State-funded program**:** ________________

CDJFS determined monthly patient liability for waiver program: ________________

I acknowledge and agree non-payment of the monthly patient liability will result in disenrollment from the state-funded program. ☐ N/A

I acknowledge and agree that services will be delivered according to my service plan, which defines service dates and amounts of service.

I understand and agree to accept responsibility for meeting service needs not met by the state-funded program or the HCBS Medicaid-funded waiver program.

I acknowledge and agree my service plan will be monitored, reviewed and ~~am~~ may be subject to change. I will contact my case manager with any questions or have the need to discuss any changes to my service plan. I will be available to meet with my case manager on a regular basis.

If enrolled in the HCBS waiver program, I acknowledge and agree to participate in an annual in-person reassessment to determine my continued eligibility for waiver enrollment.

I acknowledge and agree the State-Funded program or HCBS waiver program offers me free choice of any approved ODA-Certified Medicaid provider.

I acknowledge and agree to 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.

RELEASE OF INFORMATION

I authorize the PASSPORT Administrative Agency to release and exchange information contained within this assessment to the following only: (1) Agent/Agencies providing me with services through the State-Funded program OR a Medicaid-Funded HCBS waiver program, (2) Agent/Agencies funding services which I receive, and (3) Agent/Agencies evaluating the effectiveness of services which I receive.

Consumer's Signature	Date:
Authorized Representative (if consumer is unable to sign):	Date:
Relationship to Consumer:	Address:
Assessor or Case Manager Signature:	Date:

DISTRIBUTION: ORIGINAL TO PAA, COPY TO CONSUMER (9/2011)