Current Status: *Active* **PolicyStat ID:** *2245899*

Origination:		*03/2016*
Last Approved:		*03/2016*
Last Revised:		*03/2016*
Next Review:		*03/2017*
Owner:	*Jose Roque*	
Policy Area:	*Utilization Management*	
References:		

Habilitation Supports Waiver (Medicaid 1915 (c) Waiver)

POLICY

This policy ensures the provision of Habilitation/Supports Waiver (HSW) services to Medicaid eligible beneficiaries diagnosed with a developmental disability (DD), who reside in the community and choose to participate in the HSW program and receive Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) Level of Care (LOC).

PURPOSE

The purpose of the policy is to provide standards and procedures regarding the provision of HSW services.

APPLICATION

This policy applies to the Detroit Wayne Mental Health Authority (DWMHA) and its contractors, including the Managers of Comprehensive Provider Networks (MCPN), and their subcontractors responsible for the provision of HSW services. This serves the Medicaid eligible population with Developmental Disabilities.

KEY WORDS

Additional Mental Health Services (B3s)

Developmental Disability

Habilitation

Habilitation/Supports Waiver

Intermediate Care Facility for the Individual with Intellectual Disability (ICF/IID)LOC

Medical Necessity

Person-Centered Planning (PCP)

Qualified Mental Health Professional (QMHP)

Qualified Intellectual Disability Professional (QIDP)

Self-determination/Choice Voucher System

STANDARDS

1. DWMHA, contractors, an MCPN and its subcontractors shall develop and implement policies and procedures to ensure the provision of HSW services to Medicaid eligible consumers based upon medical necessity criteria.
2. MCPNs and subcontractors shall perform the following functions:
   a. Distribute information concerning HSW to potential enrollees and explain they have a choice of HSW providers,
   b. Assist individuals in applying for HSW enrollment,
   c. Conduct yearly level of care activity evaluations for re-certifications,
   d. Assure participants have been given freedom of choice of providers (details in the Customer Handbook).
   e. Assure the choice is documented in the IPOS.
   f. Assure there is a consent to receive HSW services in lieu of ICF/IID; (see section 3 of the attachment *MDHHS HSW Eligibility Certification Form*)
   g. Consistently review random samples of individual plans of service (IPOS) for appropriateness of waiver services in the amount, scope and duration necessary to meet the participant's needs,
   h. Ensure effective utilization management procedures are developed and implemented for HSW services,
   i. Establish and implement quality assurance and quality improvement activities,
   j. Submit quarterly case record samples as required by the Michigan Department of Health and Human Services (MDHHS) and the DWMH.
   k. Maintain the required rate of filled slots assigned by MDHHS to the DWMHA,
   l. Assess by utilizing the HSW Recertification Worksheet (pink form), each HSW recipient's level of care and eligibility prior to the expiration of the current certification to maintain continuity of care, (see the attachment *HSW Recertification Worksheet*)
   m. Ensure re-certification is completed within 365 days of the previous evaluation,
   n. Ensure certification of the need for ICF/IID level of care on section 2 of the HSW eligibility certification form (see attachment *HSW Eligibility Certification Form*)
   o. Ensure the person responsible for conducting the level of care re-evaluation is a QIDP,
   p. Review all HSW applications (HSW Recertification Worksheet [Pink Form]) to ensure verification of the following criteria:
      1. The person/beneficiary has a developmental disability,
      2. The person/beneficiary is eligible and enrolled as a Medicaid recipient,
      3. The person/beneficiary resides in a community setting or will reside in a community setting when HSW is received.
      4. The person/beneficiary requires a level of services similar to an Intermediate Care Facility for Individuals with Intellectual disability (ICF/IID),

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5. The person/beneficiary chooses to participate in the HSW in lieu of ICF/IID services,
6. The person/beneficiary receives at least one HSW habilitation service per month once enrolled,
7. The person/beneficiary or his legal representative has signed the DCH-1183 form (see attachment *MDHHS Authorization to Disclose Protected Health Information*).

q. Ensure HSW beneficiaries receive Medicaid State Plan Services or additional B-3 services, if clinically indicated.

r. Ensure each HSW enrolled beneficiary receives at least one HSW habilitation service per month in order to retain eligibility.

s. Utilize medical necessity criteria in the determination of the amount, duration and scope of services and supports to be provided.

t. Provide HSW services and supports based upon the individualized plan of service developed through the person-centered planning process.

u. Submit Medicaid encounter data to the Authority Information Technology (IT) Unit, ensuring it includes at least one habilitation HSW service for each enrolled HSW beneficiary.

v. Include in the monthly utilization report and annual re-certification process the following information:
   1. Confirmation of changes in enrollment status,
   2. Report of termination from the HSW program,
   3. Change in residency requiring transfer of the waiver to another county,
   4. Report of death

w. Ensure the HSW data is submitted to the MDHHS Web-Support Application (WSA) Database.

x. Ensure Quality Improvement processes include review and monitoring of all HSW enrolled beneficiaries to ensure criteria for HSW services are met.

y. Annually, Complete and submit to the Authority the re-certification forms at least two weeks prior their expiration.

z. Ensure the HSW re-certification form is signed by the beneficiary or by his/her guardian, by the professional staff designated as the QIDP, and by the Authority representative.

aa. Notify in writing to HSW beneficiaries and/or their legal guardians shall be notified in writing when HSW services are denied, suspended, reduced or terminated. The grievance and appeal process shall be offered to the consumer/person/guardian.

ab. Review the WSA reports to assure compliance with the timely submission of HSW required data.

ac. Complete timely the WSA system required data.

3. The Authority shall:
   a. Provide training, education and technical assistance to contractors, including MCPN and their HSW contractors.
   b. Monitor closely to promote full utilization of all available HSW slots.
   c. Review all applications prior to submission to MDHHS.
   d. Defer application if incomplete or if additional information is needed to demonstrate HSW eligibility.
   e. Facilitate quarterly meetings with the MCPN and their subcontractor to:

1. Provide HSW update information specific to MDHHS guidelines and policy,
2. Provide technical assistance and training,
3. Review contract requirements,
4. Facilitate assessment and problem solving of system-wide issues and challenges.

f. Review quarterly samples of records submitted utilizing the self-monitoring tool.

g. Review recertification applicants' entry into the MDHHS database (WSA).

h. Provide consistent and regular communication with MDHHS regarding all questions and concerns from the MCPN and their subcontractors.

i. Provide onsite reviews and technical assistance as indicated.

j. Monitor contract compliance in related to the HSW in the reporting, utilization, monitoring, and delivery of services as well as data entry.

QUALITY ASSURANCE/IMPROVEMENT

The Authority shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs of MCPNs, their subcontractors and direct contractors must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

Authority staff, MCPNs, contractors and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. Michigan Mental Health Code, P.A. 258 of 1974, as revised.
2. MDHHS Medicaid Provider Manual.
3. http://www.michigan.gov/documents/mdch/Managed_Specialty_Services_and_Supports_Program_Approved_417175_7.pdf
4. Detroit-Wayne Community Mental Health Authority Consumer Handbook

RELATED POLICIES

1. Individualized Plan of Service/Person Center Plan
2. MDHHS Medicaid Fair Hearings and Appeals

RELATED DEPARTMENTS

1. Compliance
2. Customer Service
3. Information Technology

4. Integrated Health Care
5. Managed Care Operations
6. Quality Improvement
7. Recipient Rights
8. Substance Use Disorders

CLINICAL POLICY

Yes

INTERNAL/EXTERNAL POLICY

EXTERNAL

EXHIBIT(S)

1. MDHHS HSW Eligibility Certification Form.
2. HSW Recertification Worksheet (Pink Form)
3. MDCH Authorization to Disclose Protected Health Information
4. Performance on Areas of Major Life Activities Form.
5. HSW New Applicant Worksheet (Blue Form)

Attachments:	HSW FORM - Eligibility Certification rv 7-2-14 with reset (3).pdf HSW New Applicant Worksheet Blue Form.pdf HSW Recertification Worksheet Pink Form.pdf MHHS Authorization to Disclose Protected Health Information.doc Peformance on Areas of Major Life Activities Form.doc

Approval Signatures

Approver	Date
Jeff Delay: Chief Operating Officer [AS]	03/2016
Allison Smith: Project Manager, PMP	03/2016
Dana Lasenby: Deputy Chief Operating Officer	03/2016
Carmen Mcintyre: Chief Medical Officer	03/2016
Dana Lasenby: Deputy Chief Operating Officer	03/2016
Jose Roque	03/2016

PM ☐ S ☐
RES CODE: ________
FY: 20______

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
HABILITATION SUPPORTS WAIVER (HSW) ELIGIBILITY CERTIFICATION

PRIORITY PROCESSING: ☐ Age off CWP (age 18) ☐ Age-off State Plan PDN (age 21) ☐ At imminent risk of ICF/IID (referral from CPLS)

SECTION 1

Initial Certification ☐		Annual Recertification ☐		Next Recertification Due Date:
Last Name	First Name	Medicaid # *MUST be 10-digits – include leading zeros*		Consumer Unique Id
Address		City/ Zip		Date Of Birth
DHS License # For Residence (If Applicable)		Prepaid Inpatient Health Plan		County Of Financial Responsibility
# Of Licensed Beds At Residence	Self-Determination Arrangement	Enrolled In MI Choice	Medicaid Eligible	Date Medicaid Eligibility Verified

This is to certify that the above named individual is eligible for Medicaid coverage and has received a comprehensive evaluation of his/her needs. The comprehensive evaluation and supporting documentation are available in the individual's record.

Support Coordinator Signature & Credentials ________ Date ________ Other PIHP Staff (Optional) ________ Date ________

SECTION 2

Based on the results of the comprehensive evaluation and supporting documentation, the following Waiver eligibility requirements are met:

☐ This individual has a developmental disability as defined in the Developmental Disabilities Assistance and Bill of Rights Act (P.L.106-402).

☐ If not for the availability of home and community-based services, this individual would require the level of care provided in an intermediate care facilities for Individuals with Intellectual Disabilities (ICF/IID).

☐ WAIVER RECOMMENDED

☐ WAIVER NOT RECOMMENDED

QIDP Signature & Credentials ________ Date ________ PIHP Designee (Optional) ________ Date ________

SECTION 3

Previous Consent Expires: ________________

I understand that I may accept or reject waiver services instead of services provided in an ICF/IID and that I may withdraw this consent at any time in writing. This consent may not exceed 36 months. I ☐ accept ☐ reject services as offered under the Habilitation Supports Waiver (HSW).

Signature ________ Date ________

☐ Self ☐ Legal Guardian or Parent of minor
☐ Telephone Consent Obtained (attach written consent)

Witness (required only if signature above made by a mark) ________ Date ________

SECTION 4

WAIVER ENROLLMENT:

☐ ENROLLED or ☐ RECERTIFIED EFFECTIVE DATE: ______________________

☐ NOT ELIGIBLE or ☐ DISENROLLED REASON: ______________________

IF Disenrolled, Notice of Right to Fair Hearing: Date: ______________

PIHP Designee Signature (for recertifications and disenrollments) or MDHHS Signature (for new enrollments) ________ Date ________

Must be printed on BLUE paper

HSW NEW APPLICANT WORKSHEET

PM ☐ S ☐

Res Code: _____ FY: 20___

☐ M / ☐ F Age

DOB:_______________

Name:_______________________________________ Medicaid ID#____________________

PIHP: ______________________ CMH/MCPN: ________________ County: ______________________

Residence: ____ ☐ CWP Grad ☐ Other Priority Group

DIAGNOSIS: ☐ DD / ☐ SMI

____

____

____

[Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder (ICD code 295.xx); Delusional Disorder (ICD code 297.1); Psychotic Disorder NOS (ICD code 298.9); Psychotic Disorder due to a general medical condition (ICD codes 293.81 or 293.82); Dementia with delusions (ICD code 294.42); Bipolar I Disorder (ICD codes 296.0x, 296.4x, 296.5x, 296.6x, or 296.7); or Major Depressive Disorder (ICD codes 296.2x and 296.3x)]

MEDS # anti-psychotic meds

other psych meds

HSW SERVICES Specified in the IPOS IPOS DATE: ________________

- ☐ Community Living Supports
- ☐ Enhanced Medical Equipment & Supplies
- ☐ Enhanced Pharmacy
- ☐ Environmental Modifications
- ☐ Family Training
- ☐ Goods and Services (s-d only)
- ☐ Out of Home Non-Voc Habilitation
- ☐ PERS
- ☐ Prevocational Services
- ☐ PDN (21+)
- ☐ Respite Care
- ☐ Supports Coordination
- ☐ Supported Employment

GOALS AND OBJECTIVES:

RECOMMENDATION:

☐ Enroll in HSW - all 5 criteria met)

- ☐ LOC Applied Accurately
- ☐ Meets ICF/IID LOC
- ☐ LOC Documented on HSW Cert Form
- ☐ QIDP Certified
- ☐ Given Choice between HSW or institutional care

Date Certification Signed by QIDP (Section 2) ____________

☐ PEND: Additional Information Needed (see reverse side for details)

☐ Do not Enroll in HSW

Reviewed by: ____ Date:_______________

Name: ____________________________

PIHP: ____________________________

PENDING

☐ The plan of service submitted does not provide clear information about what the individual wants to achieve in terms of outcomes that are meaningful toward goals of community inclusion & participation, independence and/or productivity, and that without these habilitation services and supports, would otherwise require ICF/IID level of care services. Please submit a revised plan of service that reflects objectives that support the individual's goals and outcomes, including amount, scope and duration.

Additional Comments:

☐ Please provide supporting documentation that identifies the onset of the developmental disability prior to the age of 22.

Additional Comments:

☐ Missing required form or signature.

- ☐ HSW Eligibility Certifications
- ☐ QIDP Signature
- ☐ Other
- ☐ Guardian Consent
- ☐ HIPAA Release

Additional Comments:

☐ Residential code is missing or incorrect in the data warehouse. Please correct and advise us once it is completed so we can run the query again.

Additional Comments:

Must be printed on PINK paper

HSW RECERTIFICATION WORKSHEET

PM ☐ S☐

☐1st ☐ 2nd ☐ 3rd ☐4th Quarter 20_____

☐ M / ☐ F Age____

DOB: ____________

Name:__________________ ___________________ Medicaid ID#_______________

PIHP: ______________________________ CMH/MCPN: __________________________

Residence: ___________________________________ County: ________________

DIAGNOSIS: DD / SMI ____

____

____

HSW SERVICES Specified in the IPOS IPOS DATE: ________________

☐ Community Living Supports
☐ Enhanced Medical Equipment & Supplies
☐ Enhanced Pharmacy
☐ Environmental Modifications
☐ Family Training
☐ Goods and Services (s-d only)
☐ Out of Home Non-Voc Habilitation
☐ PERS
☐ Prevocational Services
☐ Private Duty Nursing (21+)
☐ Respite Care
☐ Supports Coordination
☐ Supported Employment

GOALS AND OBJECTIVES:

RECOMMENDATION:

☐ LOC Documented on HSW Cert Form Date Certification Signed by QIDP (Section 2) ______________

☐ LOC Applied Accurately
☐ Meets ICF/IID LOC
☐ QIDP Certified
☐ Given Choice between HSW or institutional care

☐ PEND: Request additional Information (details on reverse side) – Date Pended: _______________

☐ DO NOT ENROLL Reason: ____

Reviewed by: ___________________________________ Date:______________

Name: ______________________________

PIHP: ______________________________

PENDING

☐ The plan of service submitted does not provide clear information about what the individual wants to achieve in terms of outcomes that are meaningful toward goals of community inclusion & participation, independence and/or productivity, and that without these habilitation services and supports, would otherwise require ICF/IID level of care services. Please submit a revised plan of service that reflects objectives that support the individual's goals and outcomes, including amount, scope and duration.

Additional Comments:

☐ Please provide supporting documentation that identifies the onset of the developmental disability prior to the age of 22.

Additional Comments:

☐ Missing required form or signature.

☐ Guardian Consent

☐ QIDP Signature

PERFORMANCE ON AREAS OF MAJOR LIFE ACTIVITIES
Habilitation Supports Waiver

Instructions
9/25/2014

In order to expedite the reviews of applicants for the HSW program, this one-page (2-sided) form has been designed. It addresses the areas of major life activities required by the Mental Health Code. The intent is to gather all the relevant information to make a determination of a developmental disability and need for ICF/IID level of services if not for the availability of HSW services. This is the preferred form. If the PIHP has supporting documentation that addresses each area of the form, that documentation may be submitted in place of the form. Please highlight the areas of major life activity and any behavioral or health issues so the DCH reviewers can locate the information easily.

The definition of developmental disability in the Mental Health Code includes a determination that the condition (i) is attributable to a mental or physical impairment or a combination of mental and physical impairments, (ii) is manifested before age 22, (iii) is likely to continue indefinitely, and (iv) results in substantial functional limitations in three or more of the following areas of major life activity:
Self-care (items a-g on the form)
Receptive and expressive language (item h on form)
Learning (item I on form)
Mobility (item j on form)
Self-direction (item k on form)
Capacity for independent living (item l on form)
Economic self-sufficiency (item m on form)

Completing the form:

Identifying information must be completed. If the person's Medicaid is pending, indicate that the number has not been received but is in process. If the person is residing in a nursing home, hospital, or ICF/IID, please indicate in the supporting documentation the plan to return the person to the community. HSW services cannot be initiated until the person is residing in the community.

Scoring:

In the boxes to the right of each item, use the key to enter the number that best reflects the person's abilities. If the skill has not been required to be demonstrated within the past seven days, report on the person's performance the last time it was completed.

For items that have several sub-tasks, as in capacity for independent living, enter the number that most accurately reflects their performance on at least 50% of the sub-tasks. For example, the person needs supervision for nutritional status, arranging transportation, and medication management. The person needs limited assistance for managing own health status, and domestic responsibility. The person needs extensive assistance to manage financial affairs. He has three sub-tasks with a score of "1" and two sub-tasks with a score of "2" and one sub-task with a score of "3". In this case, score a "3" in the box and write the scores for each sub-task somewhere in the box, either on top of each sub-task or in the comment section. Always give the person the benefit of the highest applicable score when in doubt.

For item k, self-direction, score as follows:

"4" Has a plenary guardian
"3" Has a partial guardian or activated durable power of attorney. Specify in the comment space what decision the person makes without guardian or DPOA authorization.
"0" Person has no guardian or has a durable power of attorney not activated. The person may rely on others for guidance in making decisions, but ultimately has full responsibility for his decisions.

If the comment space below each item is not sufficient, please attach an additional sheet.

KEY:

0. **INDEPENDENT** - No help or oversight – OR – Help/oversight provided only 1 or 2 times during last 7 days
1. **SUPERVISION** - Oversight, encouragement or cuing provided 3+ times during last 7 days – OR – Supervision plus physical assistance provided only 1 or 2 times during last 7 days.
2. **LIMITED ASSISTANCE** - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3+ time – OR – More help provided only 1 or 2 times during last 7 days.
3. **EXTENSIVE ASSISTANCE** - While resident performed part of activity, over last 7 day period, help of following type(s) provided 3 or more times:
   -- Weight-bearing support
   -- Full staff performance during part (but not all) of last 7 days
4. **TOTAL DEPENDENCE** - Full staff performance of activity during entire 7 days.

For the areas of the form requesting a description of behavioral issues (item #1) or health issues (item #2), only complete this if the issue is relevant.

The information that must also be included with the form (or other supporting documentation in its place) is:

- The DCH-1183 Authorization to disclose protected health information
- The signed HSW certification form
- Copy of the individual plan of services developed through the person-centered planning process. This must include the specific services that the person needs to be provided by the HSW. Remember, the person enrolled in the HSW must receive at least one waiver service each month.
- Any other pertinent information that the PIHP thinks would be helpful for the DCH to consider.

DCH Reviews:

Reviews will be completed at DCH. Inquiries about the status of a person's request should be directed to Belinda Hawks at 517-335-1134. Reviews will be completed as quickly as possible. While the review is in process, the PIHP should assure that the person receives the Medicaid services necessary to support him. DCH will send a letter to the PIHP HSW Coordinator indicating its support of the waiver enrollment or outlining issues that need to be addressed before enrollment can proceed.

NAME OF PERSON APPLYING FOR HSW: ______________________________

MEDICAID ID # ______________________ **DATE OF BIRTH:** ______________________

PERSON'S ADDRESS: ______________________________

DEVELOPMENTAL DISABILITY: ______________________ **DATE OF ONSET OF DD:** ______________

COMPLETED BY: ______________________________ **DATE:** ______________

PERFORMANCE ON AREAS OF MAJOR LIFE ACTIVITY-

0. **INDEPENDENT** - No help or oversight - or- Help/oversight provided only 1 or 2 times during the last 7 days.
1. **SUPERVISION** - Oversight, encouragement or cuing provided 3+ times during last 7 days - OR - Supervision plus physical assistance provided only 1 or 2 times during last 7 days**.**
2. **LIMITED ASSISTANCE** - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3+ times - or- More help provided only 1 or 2 times during last 7 days.
3. **EXTENSIVE ASSISTANCE** - While resident performed part of activity, over last 7 day period, help of following type(s) provided 3 or more times:
   - Weight Bearing Support
   - Full staff performance during part (but not all) of last 7 days.
4. **TOTAL DEPENDENCE -** Full staff performance of activity during entire 7 days.

**** Specify any devices or equipment needed for any area of major life activity in the space below each description and indicate performance (0-4 as described above) in the box to the right of each activity..**

a.	**BED MOBILITY**	**How person moves to and from lying position, turns side-to-side, and positions body while in bed**	
b.	**TRANSFER**	**How person moves between surfaces B to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)**	
c.	**DRESSING**	**How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis**	
d.	**EATING**	**How person eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)**	
e.	**TOILET USE**	**How person uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes**	
f.	**PERSONAL HYGIENE**	**How person maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands and perineum (EXCLUDE baths and showers)**	
g.	**BATHING**	**How person takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower.**	

h.	RECEPTIVE & EXPRESSIVE LANGUAGE	**How person communicates with others to express his desires and needs, including understanding verbal, pictorial, or written communication. Specify any devices used to communicate:**	
i.	LEARNING	**How person learns new information, generalizes what he has learned to new situations. If there is a diagnosis of Intellectual disability, please specify below:**	
j.	MOBILITY	**How person moves between locations on even surfaces. If in wheelchair, self-sufficient once in chair. Specify any mobility devices used:**	
k.	SELF-DIRECTION	**How person directs his own life. If there is a guardian, please specify the areas in which person continues to make decisions.**	
l.	CAPACITY FOR INDEPENDENT LIVING	**How person manages a household and schedule, including financial affairs (e.g., bill paying, money management), domestic responsibility (e.g., housekeeping, chores, maintenance), nutritional status (e.g., menu planning, shopping, cooking), arranging transportation if applicable, medication management and managing own health status.**	
m.	ECONOMIC SELF-SUFFICIENCY	**How person is employed and whether his income is sufficient to support himself. If working toward economic self-sufficiency, when does person expect to achieve this?**	

1. Describe any behavioral issues and the approaches agreed to during person-centered planning or attach supporting documentation with this area highlighted.

2. Describe any health issues and the approaches agreed to during person-centered planning or attach supporting documentation with this area highlighted.

3. Please enclose the following documentation:
   Signed DCH-1183 Authorization to Disclose Protected Health Information Form
   Signed HSW Certification Form
   Copy of the Individual Plan of Services.
   Any other pertinent information related to services, treatment, or supports needed by the person.

4. Name & phone number of a contact person:

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Michigan Department of Health and Human Services

Directions: *Type or Print all requested information, with exception of signatures on Page 2.*

Individual's Name (Beneficiary, Recipient, Patient, Consumer, etc.)			Individual's ID Number (Medicaid, SSN, Other)
Street Address			Individual's Date of Birth / /
City	State	ZIP Code	Phone ( ) -

I AUTHORIZE THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS) TO SHARE MY HEALTH INFORMATION:

List the amount or type of information you would like to share in the section below.
For example, you can say all my health information or list certain types of information you would like to share.

____

____

____

MDHHS MAY SHARE MY HEALTH INFORMATION WITH THE FOLLOWING PERSON OR ORGANIZATION:

____
Name of Person/Organization

____
Street Address

____
City, State, ZIP Code

( ) - ( ) -
Phone Number Fax Number

MDHHS WILL SHARE MY HEALTH INFORMATION FOR THE FOLLOWING REASON:

For example, to discuss my health care benefits or at the request of the individual.

____

____

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I do not have to sign this authorization.
- My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.
- **Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared if I initial here or if I list this type of information above __________.**
- If I authorize the release of substance use disorder treatment information, the recipient cannot re-disclose this information without my permission unless permitted under federal or state law.
- Other types of information shared under this authorization may be re-disclosed by the person or organization I identified above and may no longer be protected by federal or state law.
- I may change my mind and revoke (take back) this authorization at any time. To revoke this authorization, write to the MDHHS program that maintains your records and include a copy of the front of this form.
- Information that has already been shared based on this authorization cannot be taken back.
- I may request a copy of this signed authorization. If I have not previously revoked this authorization, it will expire on: *(list a date, event or condition)*

____

Date, Event or Condition
(Authorization will expire one year from the signature date if you leave this section blank.)

Signature of Individual or Legal Representative	Date / /
Name of Individual or Legal Representative	
Legal Representative's Relationship to Individual (i.e., Parent, Guardian, Patient Advocate, Authorized Representative, Power of Attorney. Documentation may be required.)	

MDHHS USE ONLY

This authorization was revoked:	
Signature	Date / /

AUTHORITY: This form is acceptable to the Michigan Department of Health and Human Services as compliant with HIPAA privacy regulations, 45CFR Parts 160 and 164 as modified August 14, 2002.

COMPLETION: Is voluntary, but required if disclosure is requested.

Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.