Children's Mental Health Program

RECIPIENT CHOICE FORM

1. Recipient Name:_____

2. Parent/Legal Guardian/Authorized Representative Name

_____

3. The following has been presented and discussed with the recipient and, if applicable, the parent, legal guardian or authorized representative. Please check each area that has been discussed:

- ☐ (a) All available services for which recipient is eligible under the Children's Mental Health (CMH) Program have been discussed as well as wraparound services that are available in the community but not through the CMH Program.

- ☐ (b) A choice between PRTF and Children's Mental Health Program services has been given. The recipient and, if applicable, the parent, legal guardian or authorized representative, has:

  - ☐ (c) Selected Children's Mental Health Program services

  - ☐ (d) Selected to remain in the Psychiatric Residential Treatment Facility
    Reason:_____

- ☐ (e) Survey: Individuals who choose to participate in the CMH Program must agree to participate in a survey about your experiences in the program. You will be contacted at a later date about completing the survey.

- ☐ (f) Consumer-Directed Services: Individuals have been notified that for 2 services in this program, companion and respite, there is a choice between Agency Directed Services and Consumer Directed Services. (The individual understands that, by using Consumer-Directed Services, he or she bears the responsibilities associated with employing his or her own personal attendants. NOTE: DMAS is not the employer for Consumer-Directed Services.)

- ☐ (g) The individual's right to the appeal process and a fair hearing has been explained.

- ☐ (h) The individual's (or authorized representative's) provides consent to exchange information with the Department of Medical Assistance Services (DMAS) by signing and dating this form. This consent will remain in effect until revoked by the individual (or authorized representative) in writing.

_____ _____
Signature of Recipient Date

_____ _____
Signature of Parent, Legal Guardian, Authorized Representative (underline applicable designation) Date

_____ _____
Signature of Administer of Form Date

Children's Mental Health Program

INSTRUCTIONS ON HOW TO COMPLETE THE RECIPIENT CHOICE FORM

1. Place name of individual you are determining will/will not be enrolling into the Children's Mental Health Program.

2. Place name of individual with guardianship for the above named individual.

3. Check each area (a – h) that you have discussed with the potential recipient, and/or guardian.

(a) Check this box if you have informed the potential recipient, and/or guardian of the services available for the CMH Program (i.e. Transition Coordination, Respite, Companion Care, Consumer Directed Services, Therapeutic Consultation, Family Care Giver Training, Environmental Modifications, and In-Home Residential Supports) and for the services available in the community (i.e. Therapeutic Day School, Intensive In-Home, Counseling, etc.)

(b) Check this box if you gave a choice between the Children's Mental Health Program and a Psychiatric Residential Treatment Facility.

(c) Check this above box if the potential recipient, and/or guardian are choosing the Children's Mental Health Program Services.

(d) Check this box if the potential recipient, and/or guardian have declined the Children's Mental Health Program and would like to have their child remain in the PRTF. If the potential recipient, and/or guardian have selected this box than state the reason that they are choosing this option (i.e. Individual does not have a family to return home too; Individual will not maintain Medicaid after leaving the PRTF; Individual does not meet criteria for the program; etc.)

(e) Check this box if you informed the potential recipient, and/or guardian that there will be a survey regarding their experience and satisfaction with the program and they agree to participate in this survey in regards to the CMH Program.

(f) Check this box if you have informed the potential recipient, and/or guardian of the difference between agency - directed services and consumer – directed services for Respite and Companion Care. Refer to them to Appendix B of the Children's Mental Health Manual to be fully informed on consumer-directed services and employee management.

(g) Check this box if you have informed the potential recipient, and/or guardian of the appeal process and fair hearing for denial of enrollment or denial of services within the CMH Program.

(h) Check this box if the potential recipient, and/or guardian are in agreement to sign and date this document, giving DMAS consent to exchange information; and until otherwise noted in writing, it will remain effective.

Signatures:
If over age 18, the individual enrolling into the CMH Program or declining must sign and date

Must be signed by Parent, Legal Guardian, and/or Authorized Representative if the individual enrolling or declining is a minor – or there are guardianship/ legal issues

The individual who administers this form –(i.e. Pre-screener, Transition Coordinator, Case Manager, FAPT, etc), must sign and date form and submit to DMAS via fax or mail if declining, or turned into DMAS through the Transition Coordinator/Case Manager along with enrollment paperwork.