

## Appendix 10 – Application for MSSP Under Medi-Cal Institutional Deeming Procedures

MSSP Site Name: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

Medi-Cal Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

I am applying to participate in the Multipurpose Senior Services Program (MSSP). I agree to cooperate with the MSSP staff that will determine my eligibility for the program and, if I am accepted, will work with me to obtain the social and health services that I need.

If I am eligible and choose to participate, I understand that:

- I may change my mind at any time, withdraw from the program and decide to continue living where I am. I will not be forced to make a change in my living arrangements.
- Discharge or voluntary withdrawal from MSSP will affect my eligibility for other Medi-Cal benefits. My Medi-Cal benefits are dependent upon my continuing eligibility for MSSP: if I am no longer eligible for, or voluntarily withdraw from MSSP, Medi-Cal benefits will end.
- MSSP is an alternative to living in a nursing facility. I prefer to participate in MSSP and remain in my home.
- I do not have to answer any questions that are not relevant to the determination of services I am to receive.
- I will participate in the process of deciding the services that I need. I will be notified of the services I am to receive, and any subsequent changes made to these arrangements.
- All claims submitted in my behalf for Medicare, Medi-Cal and social services will be tracked by the MSSP staff.
- All information in my MSSP case record is confidential. This includes health information, and non-health information. My non-health information, as released by my authorization, will be seen only by staff

and consultants of MSSP, those providing services to me, and as otherwise provided by law.

- My health information that I authorize to be provided to MSSP shall be maintained as confidential as required by the Health Insurance Portability and Accountability Act (HIPAA). I acknowledge that the MSSP site has provided me with a notice of HIPAA privacy practices.
- As is the case with other Medi-Cal long-term care services that I receive, because MSSP are also funded by Medi-Cal, the State may also seek recovery for those services from my estate after my death.
- I have the right to have care management/services provided by MSSP or another qualified organization.
- I will only receive MSSP services as long as federal and state funds are available. Furthermore, I will no longer be eligible for MSSP if: the cost for serving me exceeds amounts budgeted for my care; MSSP determines that I can no longer benefit from services; the imminent risk of my being institutionalized no longer exists; or if I become ineligible for Medi-Cal benefits.
- I may request a state hearing if my application for participation is denied, if I am discharged from the program, or if I am dissatisfied with services I receive.

All questions I have at this time concerning MSSP have been fully answered. When I have further questions, I should contact:

MSSP Staff Name (Print): \_\_\_\_\_ Phone: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have explained MSSP and the nature of the involvement requested of the applicant. I have answered the questions about MSSP asked by the applicant, or by persons asking on behalf of this applicant. I have given the applicant a copy of this form, and a copy of either "Client Rights" or the County's equivalent notice.

I hereby witness the above signature:

MSSP Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_