Request for Deinstitutional Services

MSSP Site: _____

Applicant's Name: _____

Medi-Cal ID:_____ Phone:_____

Street Address: _____

City/State/Zip: _____

I am requesting assistance in transitioning from living in a facility to living in the community. Specifically, I am requesting services from the Multipurpose Senior Services Program (MSSP). 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 these transition services will not affect other medical or social benefits that I am eligible to receive.
- I will participate in the process of determining the transition services that I need. I will be notified of the services I am to receive and any subsequent changes made to these arrangements.
- I do not have to answer any questions that are not relevant to the determination of services I am to receive.
- All information in my MSSP case record is confidential. It will be seen only by staff and consultants of MSSP, those providing services to me (including my managed care health plan), 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.
- I will only receive transition services as long as federal and State funds are available. I cannot receive transition services from more than one Medi-Cal funded program (e.g., California Community Transition services, etc.) at a time. 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, or if I refuse or am unable to cooperate with program requirements, such as required home visits.

- 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 may request a State Fair Hearing if my request for services is denied, if I am discharged from services, or if I am dissatisfied with the 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: _____ Phone: _____

Applicant's signature: _____ Date: _____

I hereby witness the above signature. I have:

- Explained the deinstitutionalization services, MSSP, and the nature of the involvement requested of the individual.
- Answered the questions asked by the individual, or by persons asking on behalf of this individual.
- Provided a copy of this form to the individual.
- Provided a copy of "Participant Rights" and the California Department of Social Services notice, "Your Rights Under California Public Benefits Programs" to the individual.

MSSP signature: _____ Date: _____

Applicant received a copy of this form on this date: _____