Application for MSSP under Medi-Cal Institutional Deeming Procedures

MSSP Site: _____

Applicant's Name: _____

Medi-Cal #: _____ Phone: _____

Street Address: _____ Apt #: _____

City/State/Zip: _____

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 (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.
- As is the case with other Medi-Cal long-term care services that I receive, because MSSP is also funded by Medi-Cal, the State may also seek recovery for those services from my estate after my death.
- Information in my case record is confidential. It will be seen only by staff and consultants of MSSP, those providing services to me, and as otherwise provided by law.
- I have the right to have care management/services provided by MSSP or another qualified organization of my choice.
- 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, or if I refuse or am unable to cooperate with program requirements, such as required home visits.
- I may request a State Fair 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:_____ 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 "Participant Rights" and the California Department of Social Services notice, "Your Rights Under California Public Benefits Programs".

I hereby witness the above signature:

MSSP signature: _____ Date: _____

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