Appendix 9 – Application for the Multipurpose Senior Services Program (MSSP)

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 not affect other medical or social benefits that I am eligible to receive.
- 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 on 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: ____________