MEDICAID TARGETED CASE MANAGEMENT
MEMBER ENROLLMENT FORM

PROVIDER AGENCY:

Client Name: ___________________________________ County: _________________

Date of Birth: ___________________________________ SS#: ___________________

Medicaid Number: ______________________________ Effective Date of Enrollment: ____________

Previous Agency of Record: _______________________

- I (and/or my legal representative) have been informed of my rights to Targeted Case Management Services including the right to appeal my individual service plan.
- I (and/or my legal representative) understand that my use of these services is voluntary and services may be withdrawn or ended at my request.
- I (and/or my legal representative) understand that I may choose to receive Targeted Case Management Services from any available qualified provider, and I have the right to change my case management provider if I feel services are not appropriate or sufficient to meet my needs.
- I (and/or my legal representative) understand that I may not enroll with another provider until the first day of the new calendar month.
- I (and/or my legal representative) have been informed of the definition of Targeted Case Management Services, and I understand that receiving these services does not guarantee the receipt of other services or treatments, but it is a process to help me get necessary services and/or treatment based on my individual needs.
- I (and/or my legal representative) have been informed of other case management providers available in my county.

☐ I choose to receive Targeted Case Management Services.

☐ I choose **<u>NOT</u>** to receive Targeted Case Management Services.

_______________________________________ _______________________________

Member/Legal Representative Date

_______________________________________ _______________________________

Provider Representative Date