Drug Free Mom and Babies Member (DFMB) Enrollment Form

DFMB PROVIDER NAME:

Member Name: _____

Date of Birth: _____

Effective Date of Enrollment:

Medicaid Number:

- I have been informed of my rights to receive services through a DFMB Program
- I understand that my use of these services is voluntary, and services may be withdrawn or ended at my request.
- I understand that I may choose to receive DFMB Services from any available qualified DFMB provider.
- I understand that I may not enroll with another DFMB provider until the first day of the new calendar month.
- I have been informed of the services that are available through a DFMB provider 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 understand that I cannot receive Targeted Case Management Services at the same time as I am receiving services from a DFMB Provider

☐ I choose to receive DFMB Services

☐ I choose **NOT** to receive DFMB Services

_____ _____

Member Signature Date

_____ _____

Provider Representative Date