

HABILITATION SUPPORTS WAIVER (HSW) ELIGIBILITY CERTIFICATION

Michigan Department of Health and Human Services

If Priority Processing for Initial Enrollment (check one)		
<input type="checkbox"/> Age of CWP (age 18)	<input type="checkbox"/> Age-off State Plan PDN (age 21)	<input type="checkbox"/> At imminent risk of ICF/IID

SECTION 1

<input type="checkbox"/> Initial Certification <input type="checkbox"/> Annual Recertification		Next Recertification Due Date:	
Last Name	First Name	Medicaid # (should be 10-digits include lead zeros, if any)	WSA #
Address		City	Zip
Date of Birth	MDHHS License # for Residence (if applicable)		RLA Code #
Prepaid Inpatient Health Plan	County of Financial Responsibility	# of Licensed Beds at Residence	
Enrolled in MI Health Link 1915(c) Waiver <input type="checkbox"/> Yes <input type="checkbox"/> No		Enrolled in MI Choice <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicaid Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicaid Spend Down <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>This is to certify that the above-named individual is eligible for Medicaid coverage and has received a comprehensive evaluation of his/her needs. The comprehensive evaluation and supporting documentation are available in the individual's record.</p> <p>Based on the results of the comprehensive evaluation and supporting documentation, the Waiver eligibility requirements are met.</p>			
Support Coordinator Signature and QIDP Credentials			Date
PIHP/HSW Coordinator Signature (For HSW Initial Enrollment Only)			Date

SECTION 2

Previous Consent Expires:	
<p>I understand that I may accept or reject waiver services instead of services provided in an ICF/IID and that I may withdraw this consent at any time in writing. This consent may not exceed 36 months.</p> <p>I <input type="checkbox"/> accept <input type="checkbox"/> reject services as offered under the Habilitation Supports Waiver (HSW).</p>	
Signature	Date
<input type="checkbox"/> Self <input type="checkbox"/> Legal Guardian or Parent of minor	
Witness (required only if signature above made by a mark)	Date

SECTION 3 – TO BE COMPLETED BY MDHHS FOR INITIAL ENROLLMENT

Based on the results of the comprehensive evaluation and supporting documentation, the following Waiver eligibility requirements are met:	
<input type="checkbox"/> This individual has a developmental disability as defined in the Developmental Disabilities Assistance and Bill of Rights Act (P.L. 106-402).	
<input type="checkbox"/> If not for the availability of home and community-based services, this individual would require the level of care provided in an intermediate care facilities for Individuals with Intellectual Disabilities (ICF/IID).	
<input type="checkbox"/> Waiver Recommended <input type="checkbox"/> Waiver Not Recommended	
MDHHS QIDP Signature and Credentials	Effective Date for Level of Care

SECTION 4 (Complete by MDHHS for Initial Enrollment)

Waiver Enrollment	
<input type="checkbox"/> Enrolled or <input type="checkbox"/> Recertified	Effective Date _____
<input type="checkbox"/> Not Eligible or <input type="checkbox"/> Disenrolled	Reason _____
If Disenrolled, Notice of Right to Fair Hearing Date _____	
MDHHS Signature	Date