



FREEDOM OF CHOICE CERTIFICATION

FOR FLORIDA STATEWIDE MEDICAID MANAGED CARE (SMMC) PROGRAM

Enrollee Name: \_\_\_\_\_ Authorized Representative<sup>1</sup>: \_\_\_\_\_

Medicaid ID Number: \_\_\_\_\_ Relationship to Enrollee \_\_\_\_\_

Enrollee Date of Birth: \_\_\_\_\_

- Has the Enrollee or their Authorized Representative received information on the full complement of Medicaid services available to the enrollee, including any Medicaid home and community-based service options (if applicable)?  Yes  No
• If receiving services in a nursing facility, is the Enrollee or their Authorized Representative opposed to transitioning the enrollee to the community?  Yes  No If yes, explain: \_\_\_\_\_

FREEDOM OF CHOICE CERTIFICATION:

1. My signature on this form certifies that I have read this form, or the form has been read to me, and I understand the contents of this form. I understand that by signing this form, I agree with the choice checked below. I also understand that if I change my mind and want to make another choice, my plan case manager will provide me with another form to indicate my new choice.
2. My choice is indicated by the checked box.
 I want to receive services in the community.
 I want to live in a nursing facility (if assessed need exists).

I, \_\_\_\_\_ (Enrollee/Authorized Representative) agree to the case manager attesting to my choice specified on this form.

Enrollee/Authorized Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

Enrollee/Authorized Representative Printed Name \_\_\_\_\_

Plan Case Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Plan Case Manager Printed Name: \_\_\_\_\_

<sup>1</sup> Authorized representative must be determined in compliance with applicable federal and state laws (including, but not limited to, 42 CFR Part 435, and Chapters 709, 744, and 765 of the Florida Statutes).

**NOTE:** The original certification form shall be completed and signed by the plan member (enrollee/authorized representative) and maintained in the member's plan file.

## INSTRUCTIONS FOR FREEDOM OF CHOICE CERTIFICATION

Within seven (7) days of initial enrollment and at least annually thereafter, the plan case manager shall review the Freedom of Choice Certification with the plan member (enrollee) and obtain the enrollee's signature on the completed certification.

In the enrollee information panel at the top of the form, enter the enrollee's:

- First and last name in the Enrollee Name field;
- Medicaid Identification (ID) Number; and
- Date of Birth (DOB).

If the enrollee has an authorized representative, provide:

- Representative's first and last name in the Authorized Representative field; and
- Representative's relationship to the enrollee.

If the enrollee does not have an authorized representative, enter "N/A" in the Authorized Representative and Relationship to Enrollee fields.

Determine if enrollee or his or her authorized representative has:

- Received information about Medicaid services available to the enrollee in the community; or
- Any opposition to transitioning the enrollee to the community.

If the enrollee or authorized representative responds that information about Medicaid services available in the community has not been received, then review the descriptions of home and community-based services and options for receiving Medicaid services in the community (as applicable) with the enrollee before completing the Freedom of Choice Certification.

Request that the enrollee or authorized representative read and review the Freedom of Choice Certification and indicate enrollee choice for receiving Medicaid services.

Obtain the enrollee's or enrollee authorized representative's signature above his or her printed name.

After the enrollee/authorized representative agrees to allow the case manager to attest to the choice indicated by the enrollee/authorized representative, the plan case manager shall sign and date the certification form and place it in the plan member's (enrollee) file.

A copy of the completed and signed certification shall be provided to the enrollee/authorized representative via hand delivery or mail within five (5) business days of the date of certification.