ADULT SERVICES APPLICATION

Michigan Department of Health and Human Services

FOR DEPARTMENTAL USE ONLY

1. Case Name					
2. Case Number				3. Recipient I.D. Number	
4. County	District	Section	Unit	Worker	Date

NOTE: If you need help to complete this application please indicate what kind of help you need.

☐ Bilingual Interpreter ☐ Sign-language interpreter for the deaf

☐ Other (Specify):

5. Your Full Name (of person needing or requesting services)	6. Date of Birth (mm/dd/yyyy)	7. Social Security Number
8. Your address (No., Street, City, State, Zip Code)	9. Phone or Cell Number	10. TTD No. (Teletype for the deaf)

SECTION A. DEPARTMENT PROGRAMS: Below is a brief description of the services provided by the Department.
Check the box or boxes which describe the services you need or problems where you desire help.

1. ☐ **Home Help –** Services to help pay for someone to assist with personal care and housekeeping.

2. ☐ **Adult Community Placement -** Services for adults who can no longer remain in their own homes. Includes help finding an adult foster home or home for the aged and services for people living in these settings.

3. ☐ **Other Services –** Nonpayment services to help adults stay safe in their own homes. Services may include information and referral to other community resources.

IF YOU OR SOMEONE YOU KNOW IS IN NEED OF PROTECTIVE SERVICES, CONTACT CENTRALIZED INTAKE FOR ABUSE OR NEGLECT AT 855-444-3911.

SECTION B. CURRENT SITUATION: Check all boxes that apply to you.

1. Your Status as a Recipient
   - a. ☐ Medicaid (MA) recipient
   - b. ☐ Medicaid application pending
   - c. ☐ Supplemental Security Income (SSI) recipient
   - d. ☐ Applied for SSI but did not meet income requirements
   - e. ☐ MI Choice Waiver recipient
   - f. ☐ PACE recipient
   - g. ☐ MI Health Link recipient
   - h. ☐ Community Mental Health (CMH) recipient
   - i. ☐ Food Assistance recipient
   - j. ☐ Financial Independence Program (FIP) recipient
   - k. ☐ State Disability Assistance (SDA) recipient
   - l. ☐ Veteran Affairs recipient
   - m. ☐ Other

2. Living Arrangement (Check all boxes that apply to you and answer related questions)
   - a. ☐ Alone
   - b. ☐ With husband/wife If married, answer questions below.
     - Is husband/wife disabled? ☐ Yes ☐ No
     - Is husband/wife working? ☐ Yes ☐ No
     - Full name of husband/wife _____ Date of Birth _____
   - c. ☐ With children under age 18. How many? _____
   - d. ☐ With others (relatives and non-relatives) How many? _____
   - e. ☐ Live in adult foster care facility, home for the aged.

Read the following statement, sign and date the application.

I wish to apply for one of the adult services programs. I certify that the information I have given is correct. By signing, I acknowledge that I have read and agree to the rights, responsibilities and important things to know described in Section C of this application.

Signature of Client or Authorized Representative	Date

SECTION C. SERVICES APPLICATION RIGHTS, RESPONSIBILITIES AND IMPORTANT THINGS TO KNOW:
Instructions:

- Be sure to read this information. It describes your rights and responsibilities.
- **Keep this copy for your records.**
- If you have any questions regarding your rights and responsibilities or any information provided in this section, contact the adult services worker.

1. **YOU HAVE THE FOLLOWING RIGHTS:**

Application: You have the right to apply for adult services programs at any time. Your application must be approved or denied within 45 days from the day it is received by MDHHS. When applying for Medicaid funded programs such as Home Help, you will not be approved until you have active Medicaid. If you need financial or medical assistance, another application is needed. You have the right to be notified in writing of the approval or denial of services and to be treated fairly and with dignity in all dealings with the department.

Non-discrimination: If you believe you have been discriminated against because of race, sex, religion, age, national origin, color, height, weight, marital status, sexual orientation, gender identity, handicap, or political beliefs, you have the right to file a complaint with the following:

- Michigan Department of Civil Rights – 800-482-3604
- U.S. Department of Health and Human Services – 202-619-0403

Hearings: If you believe you have been treated unfairly or a mistake has been made concerning your case, you have a right to request an administrative hearing with the Michigan Administrative Hearing System within 90 days of the action. You will be given the opportunity to explain your case to an impartial administrative law judge. You may request a hearing in any written form or you may submit the DCH-0092, Request for Hearing form, which is available online at www.michigan.gov/mdhhs-forms. All requests must be signed and dated by you or your authorized representative.

Voter Registration: If you are not registered to vote, you have the right to register.

Explanation About The Food Assistance Program (FAP):

- You may be eligible to receive food benefits.
- You may apply for the Food Assistance Program at your local MDHHS office. If you have questions, contact the Eligibility Specialist assigned to your Medicaid case.

2. **YOU HAVE THE FOLLOWING RESPONSIBILITIES:**

- You must provide MDHHS with correct and complete information about your situation. The information you give may need to be verified.

- You must report **any** changes regarding your case to your adult services worker **within ten business days** of the change. This includes, but is not limited to, changes in your medical condition or care needs, living arrangements, marital status, change in providers, hospitalizations or nursing home stays (services cannot be paid while you are in the hospital or nursing home) or any other change which may affect your eligibility or the amount of benefits.

- If you neglect or refuse to report required changes, or make false or misleading statements, you can be prosecuted for fraud. If you have any doubt about whether you should report a change, contact your adult services worker at the local MDHHS office.

Repayment of Benefits: I understand that if benefits are overpaid for any reason, the overpayment amount received will have to be repaid. In addition, if intentional misrepresentation or concealment of material information caused the overpayment, the responsible party/parties, including the provider of care, may be prosecuted for fraud.

Release of Information: I authorize the MDHHS to provide notice to my care provider(s) when Home Help services have been authorized, when there are changes in the authorization amount previously given to the provider or when my case is closed.

3. **IMPORTANT THINGS TO KNOW:**

a. Home Help and supplemental payments for Adult Foster Care/Homes for the Aged are Medicaid funded programs. I am responsible for any costs not paid by MDHHS, including benefits which may have been authorized but for which I no longer qualify due to Medicaid ineligibility.

b. I am not eligible for Home Help services prior to being certified by a Medicaid medical professional. Certification of need is provided on the DHS-54-A, Medical Needs form.

c. I understand that my Home Help provider must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS) and undergo a criminal history screening. Payment will only be made to the provider who is enrolled and approved by MDHHS to provide services for me.

d. Payment for Home Help services cannot be approved prior to (1) the medical professional's signature date on the DHS-54-A and (2) the provider enrollment and approval date.

e. I understand that my case will be reviewed every six months to determine if I continue to qualify for services.

f. I have the right to choose my Home Help provider. I understand that my provider is not employed by the State of Michigan or MDHHS. I am considered the employer and have the right to hire or fire my provider.

g. I understand that Home Help services and Adult Community Placement are benefits to me and earnings to my provider. Home Help checks may be addressed to both the client and provider (dual party). I am responsible to endorse the check and give it to my provider. If I hire an agency or reside in an adult foster care home, checks will be sent directly to the agency on my behalf.

h. I understand that payments cannot be approved for periods of time that I am in a hospital, nursing home or rehabilitation facility as this is considered duplication of Medicaid services. Payment can be approved for services provided on the day I am discharged from the hospital, nursing home or rehabilitation facility but not the day I am admitted.

i. If a reported change results in a reduction or termination of benefits, I will be notified in writing of the negative action.

j. I understand that my individual Home Help provider must record the tasks they provide for me electronically in CHAMPS. An exception may be granted for my provider to submit a paper services verification if they meet certain criteria.

k. I understand that my individual Home Help provider must submit an electronic or paper services verification before they can be paid.

MEDICAL NEEDS

Michigan Department of Health and Human Services

INSTRUCTIONS: To be completed annually by a physician, nurse practitioner, physical or occupation therapist. Please print or type.

Case Name				
Case Number		Recipient ID Number		
Patient's Name			Patient's Birth Date	
County	District	Section	Unit	Specialist
Specialist		Specialist Phone Number ( )		

Medical Provider:
We would appreciate your cooperation in completing the spaces checked below. In addition to a physician, Box A may be completed by a physician's assistant, certified nurse-midwife, ob-gyn nurse practitioner or ob-gyn clinical nurse specialist. Providers must be Medicaid enrolled. An addressed, prepaid envelope is enclosed for your convenience.

You are hereby authorized to release the information requested below to the Michigan Department of Health and Human Services.

Patient's or Representative's Signature	Patient's Name	Signature Date
Authorized Specialist's Signature	Signature Date	Local MDHHS Office

☐ **A**	Pregnancy Delivery (Expected) Date	Number of medically verified unborn children
☐ **B**	Diagnosis(es) / Treatment plan for this patient	
☐ **C**	Chronic ongoing illness ▶ ☐ YES ☐ NO	
☐ **D**	Estimated number of office or clinic visits _____ times per ☐ week ☐ month ☐ quarter ☐ Other (Please Specify)	Will this change? ☐ YES, When _____ (Date) ☐ NO
☐ **E**	Give estimated number of months for the diagnosis in B that medical treatment will be required ☐ Lifetime	
☐ **F**	Is the patient non-ambulatory? ☐ YES ☐ NO	If Yes, explain:
☐ **G**	Does patient need special transportation? If Yes, indicate mode of transportation needed (e.g., van with wheelchair lift, ambulance, etc.) ☐ YES ☐ NO ▶	
☐ **H**	Does someone need to accompany the patient to the medical appointment? ☐ YES ☐ NO ▶	If yes, who / why?
☐ **I**	Do you certify the patient has a medical need for assistance with any of the personal care activities listed below? ▶ ☐ YES ☐ NO Eating, Toileting, Bathing, Grooming, Dressing, Transferring, Mobility, Taking Medications, Meal Preparation, Shopping, Laundry, Housework	Check any complex care services needed. ☐ Specialized Feeding ☐ Suctioning ☐ Catheters or Leg Bags ☐ Bedsore Prevention ☐ Colostomy Care ☐ Range of Motion ☐ Bowel Program ☐ Other _____
☐ **J**	Can patient work at usual occupation? ☐ YES ☐ YES, but with limitations (Specify below) ☐ NO (How long): Can Patient work at any job? ☐ YES ☐ YES, but with limitations (Specify below) ☐ NO (How long):	
☐ **K**	Other (Explain)	
☐ **L**	Is the spouse or parent of the above disabled individual needed in the home to provide care? ☐ YES ☐ NO Spouse or parent cannot engage in work due to the extent of care required. ☐ YES ☐ NO How long:	

Date patient was last seen	Are you a Medicaid enrolled provider? ☐ YES ☐ NO
Name and title (Print or type)	MA enrolled Provider Signature
National Provider Identifier (NPI) Number	Signature Date / Telephone Number

AUTHORITY: Federal 45 CFR of 233.20, CFR 440.10 and CFR 440.20
COMPLETION: Voluntary
PENALTY: Benefits may be affected.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.