FREEDOM OF CHOICE SURVEY FOR CHILDREN RECEIVING PRIVATE DUTY NURSING (PDN) WHO HAVE BEEN REFERRED TO THE CHILDREN'S MULTIDISCIPLINARY ASSESSMENT TEAM (CMAT) FOR FLORIDA STATEWIDE MEDICAID MANAGED CARE (SMMC) PROGRAM

SECTION 1: ENROLLEE INFORMATION			
Enrollee Name:		Authorized Representative:[1]	
Medicaid ID Number:		Relationship to Enrollee:	
Date of Birth:			

SECTION 2: SERVICES AVAILABLE TO ENROLLEE

The Enrollee or their Authorized Representative was given information on the full complement of Medicaid services available to the enrollee, including any Medicaid home and community-based service options. Check each that was specifically discussed:

☐ Care Coordination
☐ PPEC
☐ Private Duty Nursing
☐ Medical Equipment and Supplies
☐ Transportation
☐ Plan Expanded Benefits
☐ iBudget Waiver Services, including Home and Vehicle Modifications

SECTION 3: 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 and confirm the contents of this form. I understand that by signing this form, I agree with the choices checked below.
2. My choice **right now** is indicated by the checked box.
   ☐ I want my child to continue to live at home or in a community setting.
   ☐ I want my child to move to a nursing facility (if child meets nursing facility medical guidelines).

I certify the box checked above is my choice.	
Enrollee/Authorized Representative Signature:	Date:
Enrollee/Authorized Representative Printed Name:	

SECTION 4: PLAN CASE MANAGER ATTESTATION

I attest I provided detailed information on the full complement of Medicaid services available to the enrollee, including any Medicaid home and community-based service options and relevant plan expanded benefits. This form is accurate and complete.

Plan Case Manager Signature:	Date:
Plan Case Manager Printed Name:	

[1] 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 SURVEY FOR CHILDREN RECEIVING PRIVATE DUTY NURSING (PDN) WHO HAVE BEEN REFERRED TO THE CHILDREN'S MULTIDISCIPLINARY ASSESSMENT TEAM (CMAT)

Within two (2) business days of referral to CMAT, the plan case manager shall review the Freedom of Choice Survey with the plan member (enrollee) and obtain the enrollee's signature on the completed form.

SECTION 1:

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

- 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.

SECTION 2:

The Plan Case Manager shall describe in plain language and in detail all Medicaid services available to the Enrollee, including any Medicaid home and community-based service options and relevant plan expanded benefits. Check the box for each service discussed.

SECTION 3:

The Plan Case Manager shall explain this section and allow the enrollee/authorized representative to indicate their choice. Obtain the enrollee's or enrollee authorized representative's signature above his or her printed name.

SECTION 4:

The Plan Case Manager shall sign and date the attestation and place the completed survey in the plan member's (enrollee) file. A copy of the completed and signed survey shall be provided to the enrollee/authorized representative via hand delivery or mail within five (5) business days of the date of certification.

AmeriHealth Caritas
Florida

Discrimination is against the law

AmeriHealth Caritas Florida complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently based on race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation.

AmeriHealth Caritas Florida:

- Provides free (no-cost) aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free (no-cost) language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, contact AmeriHealth Caritas Florida at **1-855-355-9800 (TTY 1-855-358-5856)**. We are available 24 hours a day, seven days a week.

If you believe that AmeriHealth Caritas Florida has failed to provide these services or has discriminated against you in another way, you or your authorized representative (if we have your written authorization on file) can file a grievance with:

- Grievances and Appeals, P.O. Box 7368, London, KY 40742. Phone: **1-855-371-8078 (TTY 1-855-371-8079),** or Fax: **1-855-358-5847**.
- You can file a grievance by mail, fax, or phone. If you need help filing a grievance, AmeriHealth Caritas Florida Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (TTY 1-800-537-7697)

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html.

English: This information is available for free in other languages. Please contact our customer service number at **1-855-355-9800 (TTY 1-855-358-5856)**, 24 hours a day, seven days a week. If your primary language is not English, or to request auxiliary aids, assistance services are available to you, free of charge.

Spanish: Esta información está disponible en otros idiomas de forma gratuita. Póngase en contacto con nuestro número de servicios al cliente al **1-855-355-9800 (TTY 1-855-358-5856)**, las 24 horas del día, los siete días de la semana. Si su idioma principal no es el inglés, o necesita solicitar ayudas auxiliares, hay servicios de asistencia a su disposición de forma gratuita.

Haitian Creole: Enfòmasyon sa yo disponib gratis nan lòt lang. Tanpri kontakte ekip sèvis kliyan nou an nan **1-855-355-9800 (TTY 1-855-358-5856)**, 24 è sou 24, sèt jou sou sèt. Si anglè pa lang manman w oswa si w ta renmen mande yon èd konplemantè, ou ka resevwa sèvis ki gratis pou ede w.

Vietnamese: Thông tin này có sẵn miễn phí ở các ngôn ngữ khác. Vui lòng liên lạc bộ phận dịch vụ khách hàng của chúng tôi theo số **1-855-355-9800 (TTY 1-855-358-5856)**, 24 giờ một ngày, bảy ngày trong tuần. Nếu ngôn ngữ chính của quý vị không phải là tiếng Anh, hoặc để yêu cầu các thiết bị trợ giúp bổ sung, thì quý vị có thể sử dụng miễn phí các dịch vụ hỗ trợ.

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