# FREEDOM OF CHOICE CERTIFICATION

## FOR FLORIDA STATEWIDE MEDICAID MANAGED CARE (SMMC) PROGRAM

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|---|---|---|---|
| **Enrollee or Child Name:** | ____ ______________ | **Authorized Representative:** | _______________________________ |
| **Medicaid ID Number:** | __________________ | **Relationship to Enrollee** | _______________________________ |
| **Enrollee Date of Birth:** | __________________ | **Parent/Legal Guardian:** | _______________________________ |

- Has the Enrollee or their Authorized Representative received information about Medicaid home and community-based services available to the enrollee in the community? ☐ Yes ☐ No ☐ N/A
- Has the Parent/Legal Guardian received information on the full complement of Medicaid services available to the family/child in the community? ☐ Yes ☐ No ☐ N/A
- Is Enrollee or their Authorized Representative or Parent/Legal Guardian opposed to transitioning the enrollee to the community (or maintaining enrollee in the community)? ☐ Yes ☐ No ☐ Not able to transition at this time.

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| **Long-term Care (LTC) Enrollees** | **Managed Medical Assistance (MMA) Enrollees Only** |
|---|---|
| 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 care/case manager will provide me with another form to indicate my new choice of long-term care assistance. | 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 care/case manager will provide me with another form to indicate my new choice. |
| 2. My choice is indicated by the checked box.<br>☐ I want to receive Home and Community-Based Services.<br>☐ I want to live in a Nursing Facility.<br>☐ I do not want to receive Long-term Care Services through the LTC Program. | 2. My choice is indicated by the checked box.<br>☐ I want to receive services in the community.<br>☐ I want to live in a Nursing Facility (if assessed need exists).<br>☐ I do not want to receive services. |

I, _______________________________ *(Enrollee/Authorized Representative or Parent/Legal Guardian)* agree to the care/case manager attesting to my choice specified on this form.

_____________________________________________________________ ___________________

Enrollee/Authorized Representative or Parent/Legal Guardian Signature Date

_____________________________________________________________

Enrollee/Authorized Representative or Parent/Legal Guardian Printed Name

**Plan Care/Case Manager Signature:** _________________________________ **Date:** ______

**Plan Care/Case Manager Printed Name:** ___ ______________