CFEEC Evaluation Request Form



For Mainstream plan member requiring non-covered LTC benefits

SECTION 1. Managed	Care	Plar	ı Informa	ation					
Medicaid health plan you are MLTC plan you are transferring									
SECTION 2. Plan Mem	ıber	Infor	mation						
Last Name			First Name				Midd	le Initial	Date of Birth (mm/dd/yyyy)
Medicaid ID			Gender Male Female	Telephone Number (with Area Code)			Cell Phone (with Area Code)		
Permanent Address			Wate Telliale			City			
County		State	Zip Code			Email Address			
AUTHORIZED REPRESENTATIVE									
Last Name			First Name				Midd	le Initial	Relationship to Member
Address			City			County	l	State	Zip Code
Telephone Number (with Area Code) Cell Phone (with Area Cod	e)	Ema	il Address			

SECTION 3. Acknowledgement/Release of Medical Information

I understand:

- That I must join a Managed Long Term Care Plan (MLTC Plan) to receive Medicaid community-based long term care (cbltc) services in my county.
- The differences between a Medicaid health plan and a MLTC Plan and that I will lose some benefits.
- I may not be able to see my doctors if I change to a MLTC Plan.
- The Conflict Free Evaluation and Enrollment Center (CFEEC) must determine I need more than 120 days of cbltc services and that I am nursing home eligible, before I can join a plan. A CFEEC nurse will contact me to schedule an evaluation.
- I give my Provider permission to give all needed medical information only if it is relevant to my request to transfer to a long term care plan. This may include any disability information needed to confirm needed services that are not available in my Medicaid health plan.

Sign Here		Plan Member	Date
		Authorized Representative's Signature	Date

SECTION 4. Physician Authorization

A Physician must fill out this Section	on including the Provider Information/Signature Box listed below.						
Ι	hereby confirm that						
Physician Name Patient Name Patient Name							
	elow which makes him/her a candidate to transfer						
from a Medicaid Health Plan to a Ma	inaged Long Term Care Plan.						
4a. Please add check mark ✓ to	o all that apply.						
necessary to assure the hea	Internal and external physical adaptations to the home, which are alth, welfare, and safety of the individual, enable the individual to endence in the home, and prevent institutionalization.						
4b. Provider Information/Signatu	re						
Physician Name:							
Specialty:							
	State: Zip Code:						
Phone:	Fax:						
Signature (sign digitally):							
SECTION 5. Managed Long	Term Care Plan (MLTC Plan)						
Provide the name of the MLTC Plan on behalf of the applicant.	representative who is submitting this form						
Plan Representative:							
Name:							
	Date:						
Signature.	Phone Number ()						