CONSENT FOR VOLUNTARY SUSPENSION OF AUTHORIZED SERVICES IN THE FLORIDA MEDICAID STATEWIDE MEDICAID MANAGED CARE PROGRAM

Enrollee's Name | **Enrollee's Medicaid Identification Number**

Enrollee's Date of Birth | **Parent/Legal Guardian**

Enrollee's Address

I understand the following services have been prescribed by my / my child's (**circle one**) physician and authorized by _____ from ___ / ___ / ____ through ___ / ___ / ____.
(Florida Medicaid Health Plan) (Date) (Date)

Authorized Services:

I understand that I do not have to accept all of the services I / my child (**circle one**) am/is authorized to receive, and it is my choice to decline, some / all **(circle one)** of these services for the current authorized dates and times.

I choose not to have the following services for me / my child (**circle one**) for the following authorized dates and times.

Declined Services:

I understand I / my child (**circle one**) remain(s) authorized to receive the total services listed above for the current authorized dates and times. It is my choice to decline these services for only these dates and times listed above. I understand this choice will not be considered as a change in the need for these services when it is time to renew the services for future dates. I also understand I may change my mind at any time and I / my child (**circle one**) may receive all of the authorized services during the remainder of the current authorized dates.

Enrollee* or Parent / Legal Guardian Signature | Date

Enrollee or Parent / Legal Guardian Printed Name

Florida Medicaid Health Plan Representative Signature | Date

Florida Medicaid Health Plan Representative Printed Name

***An enrollee 18 years of age or older, acting as his or her own legal guardian.**

CONSENT FOR VOLUNTARY SUSPENSION OF AUTHORIZED SERVICES IN THE FLORIDA STATEWIDE MEDICAID MANAGED CARE PROGRAM

Instructions

1. Enrollee Information

This form is for use only when an enrollee is receiving services and the enrollee (or parent or legal guardian) chooses to receive fewer services than are authorized for the enrollee by the Medicaid health plan. This consent ensures that the voluntary suspension will not be considered in approval of any future service needs.

Fill in the blanks with the enrollee's name, address, date of birth, Medicaid identification number, and parent or legal guardian if applicable. Except for signatures, print all written information added to the form. Health plan care coordinators may complete the form for the enrollee except for the enrollee/parent/legal guardian's signatures.

2. Authorized Services

Add the dates, and times if applicable, for the current authorized services. For example:

- I understand the following services have been prescribed by (my)/ my child's (**circle one**) physician and authorized by (Health Plan Name) from 05/02/2017 through 06/01/2017.

In the box labeled "Authorized Services," list the services authorized by the enrollee's health plan. For example:

- Private duty nursing services, eight hours per day, seven days a week.

3. Declined Services

In the box labeled "Declined Services," list the authorized services being declined. Services may be declined in part or in total. Provide any information necessary to ensure the enrollee/parent/legal guardian's wishes are upheld. For example:

- Private duty nursing services each day on Saturday and Sunday for four hours from 8:00 a.m.-12:00 p.m.
- Private duty nursing services from 05/17/2017 through 05/25/2017.

The enrollee/parent/legal guardian must be given the opportunity to review the form for correctness and allowed to revise the form as appropriate.

4. Signatures and Dates

The health plan care coordinator and the enrollee/parent/legal guardian both must sign and date the consent form. If the consent is given during an in-person meeting, all signatures and dates should be completed at the meeting. If the consent is not in person, the health plan care coordinator may sign and date the consent on the day of consent and the enrollee/parent/legal guardian must sign and date the consent form at the next home visit.

5. Record Keeping

Mail a copy of the signed and dated form to the enrollee/parent/legal guardian at the address provided on the form.

The health plan must keep the completed, signed form in the enrollee's record.