CFEEC Evaluation Request Form



For Mainstream plan member requiring non-covered LTC benefits

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n now:						
to:						
er Infor	mation					
Last Name			First Name		Date of Birth (mm/dd/yyyy)	
Medicaid ID			Telephone Number (with Area Code)		Cell Phone (with Area Code)	
	inale i emale	I	City			
County State			Email Address			
			1			
	First Name			Middle Initia	Relationship to Member	
	City		County	State	Zip Code	
Telephone Number (with Area Code) Cell Phone (with Area Code) Email A		I Address		
	n now: g to: per Infor	n now: g to: Der Information First Name Gender Male Female State Zip Code First Name City	Gender Telephone Number Gender Telephone Number Male Female State Zip Code First Name City	n now: Sto: Ger Information First Name Gender Male Female Telephone Number (with Area Code) City State Zip Code Email Address First Name City County	n now:	

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

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 Physician 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 ()					