HABILITATION SUPPORTS WAIVER (HSW) ELIGIBILITY CERTIFICATION

Michigan Department of Health and Human Services

If Priority Processing for Initial Enrollment (check one)

☐ Age of CWP (age 18) ☐ Age-off State Plan PDN (age 21) ☐ At imminent risk of ICF/IID

SECTION 1

☐ Initial Certification ☐ Annual Recertification		Next Recertification Due Date:	
Last Name	First Name	Medicaid # (should be 10-digits include lead zeros, if any)	WSA #
Address	City		Zip
Date of Birth	MDHHS License # for Residence (if applicable)		RLA Code #
Prepaid Inpatient Health Plan	County of Financial Responsibility	# of Licensed Beds at Residence	
Enrolled in MI Health Link 1915(c) Waiver ☐ Yes ■ No		Enrolled in MI Choice ☐ Yes ■ No	
Medicaid Eligible ■ Yes ☐ No		Medicaid Spend Down ☐ Yes ☐ No	

This is to certify that the above-named individual is eligible for Medicaid coverage and has received a comprehensive evaluation of his/her needs. The comprehensive evaluation and supporting documentation are available in the individual's record.

Based on the results of the comprehensive evaluation and supporting documentation, the Waiver eligibility requirements are met.

Support Coordinator Signature and QIDP Credentials Date

X -

PIHP/HSW Coordinator Signature (For HSW Initial Enrollment Only) Date

SECTION 2

Previous Consent Expires:

I understand that I may accept or reject waiver services instead of services provided in an ICF/IID and that I may withdraw this consent at any time in writing. This consent may not exceed 36 months.

I ☐ accept ☐ reject services as offered under the Habilitation Supports Waiver (HSW).

Signature Date

☐ Self ☐ Legal Guardian or Parent of minor

Witness (required only if signature above made by a mark) Date

SECTION 3 – TO BE COMPLETED BY MDHHS FOR INITIAL ENROLLMENT

Based on the results of the comprehensive evaluation and supporting documentation, the following Waiver eligibility requirements are met:

☐ This individual has a developmental disability as defined in the Developmental Disabilities Assistance and Bill of Rights Act (P.L.106-402).

☐ If not for the availability of home and community-based services, this individual would require the level of care provided in an intermediate care facilities for Individuals with Intellectual Disabilities (ICF/IID).

☐ **Waiver Recommended** ☐ **Waiver Not Recommended**

MDHHS QIDP Signature and Credentials	Effective Date for Level of Care

SECTION 4 (Complete by MDHHS for Initial Enrollment)

Waiver Enrollment

☐ Enrolled or ☐ Recertified Effective Date _____

☐ Not Eligible or ☐ Disenrolled Reason _____

If Disenrolled, Notice of Right to Fair Hearing Date _____

MDHHS Signature Date