CFEEC Evaluation Request Form

For Mainstream plan member requiring non-covered LTC benefits

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SECTION 1. Managed Care Plan Information

Medicaid health plan you are in now: _____

MLTC plan you are transferring to: _____

SECTION 2. Plan Member Information

Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yyyy)

Medicaid ID	Gender ☐ Male ☐ Female	Telephone Number (with Area Code)	Cell Phone (with Area Code)

Permanent Address	City

County	State	Zip Code	Email Address

AUTHORIZED REPRESENTATIVE

Last Name	First Name	Middle Initial	Relationship to Member

Address	City	County	State	Zip Code

Telephone Number (with Area Code)	Cell Phone (with Area Code)	Email 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**

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SECTION 4. Physician Authorization

A Physician must fill out this Section including the Provider Information/Signature Box listed below.

I _____ hereby confirm that _____
Physician Name Patient Name

requires the service/services listed below which makes him/her a candidate to transfer from a Medicaid Health Plan to a Managed Long Term Care Plan.

4a. Please add check mark ✓ to all that apply.

- ☐ Environmental Modification: Internal and external physical adaptations to the home, which are necessary to assure the health, welfare, and safety of the individual, enable the individual to function with greater independence in the home, and prevent institutionalization.
- ☐ Home Delivered Meals
- ☐ Social Day Care

4b. Provider Information/Signature

Physician Name: _____

Specialty: _____

License #: _____

Name of Clinic/Facility: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Signature (sign digitally): _____

SECTION 5. Managed Long Term Care Plan (MLTC Plan)

Provide the name of the MLTC Plan representative who is submitting this form on behalf of the applicant.

Plan Representative:

Name: _____

Title: _____ Date: _____

Signature: _____ Phone Number: ( ) _____