FREEDOM OF CHOICE SURVEY FOR CHILDREN RECEIVING PRIVATE DUTY NURSING (PDN)
WHO HAVE BEEN REFERRED TO THE CHILDREN'S MULTIDISCIPLINARY ASSESSMENT TEAM (CMAT)
FOR FLORIDA STATEWIDE MEDICAID MANAGED CARE (SMMC) PROGRAM

SECTION 1: ENROLLEE INFORMATION			
Enrollee Name:		Authorized Representative[1]:	
Medicaid ID Number:		Relationship to Enrollee:	
Date of Birth:			

SECTION 2: SERVICES AVAILABLE TO ENROLLEE

The Enrollee or their Authorized Representative was given information on the full complement of Medicaid services available to the enrollee, including any Medicaid home and community-based service options. Check each that was specifically discussed:

☐Care Coordination ☐Medical Equipment and Supplies ☐iBudget Waiver Services, including Home and Vehicle Modifications
☐PPEC ☐Transportation
☐Private Duty Nursing ☐Plan Expanded Benefits

SECTION 3: FREEDOM OF CHOICE CERTIFICATION

1. My signature on this form certifies that I have read this form or the form has been read to me, and I understand and confirm the contents of this form. I understand that by signing this form, I agree with the choices checked below.

2. My choice **right now** is indicated by the checked box.
   ☐ I want my child to continue to live at home or in a community setting.
   ☐ I want my child to move to a nursing facility (if child meets nursing facility medical guidelines).

I certify the box checked above is my choice.

Enrollee/Authorized Representative Signature	Date
Enrollee/Authorized Representative Printed Name:	

SECTION 4: PLAN CASE MANAGER ATTESTATION

I attest I provided detailed information on the full complement of Medicaid services available to the enrollee, including any Medicaid home and community-based service options and relevant plan expanded benefits. This form is accurate and complete.

Plan Case Manager Signature	Date
Plan Case Manager Printed Name:	

[1] *Authorized representative must be determined in compliance with applicable federal and state laws (including, but not limited to, 42 CFR Part 435, and Chapters 709, 744, and 765 of the Florida Statutes).*

NOTE: *The original certification form shall be completed and signed by the plan member (enrollee/ authorized representative) and maintained in the member's plan file.*

INSTRUCTIONS FOR FREEDOM OF CHOICE SURVEY FOR CHILDREN RECEIVING PRIVATE DUTY NURSING (PDN) WHO HAVE BEEN REFERRED TO THE CHILDREN'S MULTIDISCIPLINARY ASSESSMENT TEAM (CMAT)

Within two (2) business days of referral to CMAT, the plan case manager shall review the Freedom of Choice Survey with the plan member (enrollee) and obtain the enrollee's signature on the completed form.

SECTION 1:

In the enrollee information panel at the top of the form, enter the enrollee's information:

- First and last name in the Enrollee Name field;
- Medicaid Identification (ID) Number; and
- Date of Birth (DOB).

If the enrollee has an authorized representative, provide:

- Representative's first and last name in the Authorized Representative field; and
- Representative's relationship to the enrollee.

If the enrollee does not have an authorized representative, enter "N/A" in the Authorized Representative and Relationship to Enrollee fields.

SECTION 2:

The Plan Case Manager shall describe in plain language and in detail all Medicaid services available to the enrollee, including any Medicaid home and community-based service options and relevant plan expanded benefits. Check the box for each service discussed.

SECTION 3:

The Plan Case Manager shall explain this section and allow the enrollee/authorized representative to indicate their choice. Obtain the enrollee's or enrollee authorized representative's signature above his or her printed name.

SECTION 4:

The Plan Case Manager shall sign and date the attestation and place the completed survey in the plan member's (enrollee) file. A copy of the completed and signed survey shall be provided to the enrollee/authorized representative via hand delivery or mail within five (5) business days of the date of certification.