Name of Consumer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chart # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For use by Health Home eligible Consumer

I have met with my Care Manager/Case Manager for Health Home Services provided by Edwin Fair Community Mental Health Center who has explained the program to me and the care management services I can get, I have decided NOT to join at this time.

Reason for Opting Out: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that by signing this form I will not receive Health Home services, but I will still continue to get my Medicaid health care services.

If, at a later time, you decide you want to participate in Health Home, you may do so at any time.

Please contact Edwin Fair Community Mental Health Center

1-800-566-1343

Signature of Consumer, Parent, Guardian or Date

Authorized Representative

**For use by Care Manager**

I have discussed Health Home Services provided by Edwin Fair Community Mental Health Center with

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the benefits of membership were explained, however the

*Name of Health Home Consumer*

Consumer has decided not to join at this time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EFCMHC staff w/title or Credentials Date