PM ☐ S ☐
RES CODE: _____
FY: 20_____

Reset

MDHHS Date Received Stamp	PIHP Date Received Stamp

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
HABILITATION SUPPORTS WAIVER (HSW) ELIGIBILITY CERTIFICATION

IF PRIORITY PROCESSING CHECK ONE: ☐ **Age off 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 # ***MUST be 10-digits – include leading zeros***	WSA #
Address		City/ Zip	Date Of Birth
DHS License # For Residence (If Applicable)		Prepaid Inpatient Health Plan	County Of Financial Responsibility

# Of Licensed Beds At Residence	Enrolled in MI Health Link	Enrolled In MI Choice	Medicaid Eligible	Date Medicaid Eligibility Verified

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.

Support Coordinator Signature & Credentials _____ Date _____ Other PIHP Staff (Optional) _____ Date _____

SECTION 2

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**

QIDP Signature & Credentials _____ Date _____ PIHP Designee (Optional) _____ Date _____

SECTION 3

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
☐ Telephone Consent Obtained (attach written consent)

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

SECTION 4

WAIVER ENROLLMENT:

☐ **ENROLLED** or ☐ **RECERTIFIED** **EFFECTIVE DATE:** _____

☐ **NOT ELIGIBLE** or ☐ **DISENROLLED** **REASON:** _____

IF Disenrolled, Notice of Right to Fair Hearing: Date: _____

_____ _____
*PIHP Designee Signature (for recertifications and disenrollments) **OR** MDHHS Signature (for new enrollments) Date