Reason for Completing This Form (please circle one)

New Member       Adding a Vendor                Changing a Vendor

Services Available

Youth Name:___________________________Guardian Name:__________________________

Date:_________________________________

Vendors and services available through Magellan have been explained to me.

I understand that I can make the decisions about what services will be provided to me or my youth. I can make the decisions about which providers will work with my youth while he/she is a member of Magellan.

I understand that I/my youth have has a right to change my provider(s) at any time for any reason. Magellan vendors also have a right to stop providing services. But they must give a 30-day written notice to me/my youth.

I understand that I/my youth have has the right to ask for informal dispute resolution or an administrative hearing if we are not given the choice of services or providers.

Provider Chosen

A list of Magellan vendors has been shared with me and my questions have been answered. I have chosen to work with the following.

Vendor(s):_____________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Family care coordinator
(required):_____________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

(Potential) Team members

Family support partner:__________________________________________________________

Mental health professional:_______________________________________________________

School representative:___________________________________________________________

Other (please specify):___________________________________________________________

Rev 6/26/15
Signatures

Signature of applicant/parent/guardian/legally responsible representative:
__________________________________________________________________________

Date:__________________________________________________________________________

Signature of witness (ONLY IF SIGNATURE IS AN “X”):_______________________________
Date:__________________________________________________________________________

Signature of Family Care Coordinator:_____________________________________________
Date:__________________________________________________________________________

Independent Assessor – include this form with the application for High Fidelity Wraparound. To submit:

- Scan the completed document to your computer.
- From the left menu, select Referral/Care Management under My Wyoming.
- Click “Upload Scanned Referral Information“ and follow prompts.