**Instructions:** Family Care Coordinators (FCC) will need to upload this document to the documents tab in the Electronic Health Record. FCCs will also need to complete a Choice of Provider custom assessment in the Electronic Health Record and sign as the Family Care Coordinator.

# Assessment Name: Choice of Provider

## Demographics

1. Youth's Name

2. Date of Assessment

   ___ / ___ / _____

3. Date of Birth

   ___ / ___ / _____

4. Reason for Completing this Form.

   ☐New Member ☐Adding a Provider ☐ Changing a Provider

## Guardian Agreements

1. Providers and services available through Magellan have been explained to me.

   ☐ Yes ☐ No

2. I understand Family Care Coordination and for 1915 (C) waiver participants, family or youth support are mandatory services that we must participate in while enrolled in High Fidelity Wraparound.

   ☐ Yes ☐ No

3. I can make decisions about which providers will work with my youth while they are a member of Magellan Care Management Entity Services (High Fidelity Wraparound).

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

5. I understand that I/my youth have/has the right to ask for the complaint process, the grievance process, or an administrative hearing if not given the choice of services/providers.

   ☐ Yes ☐ No

6. I have chosen to work with the following Family Care Coordinator and Agency (if applicable). (This is a person who takes responsibility for making the wraparound process happen for a family. This is through care coordination of Child and Family Team Meetings, documenting the process, and coordinating with professionals.)

7. Back-up Family Care Coordinator: I have chosen to work with the following Family Care Coordinator and Agency (if applicable) in the case that the above Family Care Coordinator is unavailable. (Maximum of 2-week time period)

## Supporting Roles (Ask your provider for a list of optional Supporting Roles in your area to add to your team. You may have the options for in person services or through telehealth.)

1. I have chosen to work with the following Family Support Partner. (The Family Support Partner can help you navigate uncomfortable situations. They can help you identify and engage with your team.)

2. I have chosen to work with the following Youth Support Partner. (A Youth Support Partner works directly with the youth to support and build skills.)

## Services (Ask your provider for a list of optional services in your area to add to your team. You may have the options for in person services or through telehealth.)

1. I have chosen to work with the following Youth Support Partner Group Leader. (Groups are two or more youth that can provide skill building. Check with your provider to decide which group would best fit for your youth.)

2. Respite (Respite is a short-term, temporary service. It provides relief from the daily burdens of care.)

3. Youth and Family Training (Youth and Family Training is mandatory for youth who before joining Magellan, did not have active Medicaid. These families would be on 1915(c) Wavier. This training is done one-on-one or in small groups of two to five. It is helps build skills like social learning or peer to peer learning. Ask your Family Care Coordinator if this is right for your child's plan of care.)

## Clinical Eligibility Assessors

1. Independent Assessor (Please enter your requested Independent Assessor)

2. Qualified Mental Health Professional (Please enter your preferred QMHP with license)

3. Phone or Email for Qualified Mental Health Professional

## The undersigned parent and/or legal guardian does hereby acknowledge that they have been given a choice of services to be received.

1. Guardian Name and Signature (Please print name of Guardian and sign below.)

___ / ___ / _____

Signature Date