LA CSoC
Member's Freedom of Choice

Section I: Identifying Information				
Recipient/Child's Name:				Date of Birth:
Physical Address:				City:
State:	Zip Code:			Phone Number:
Social Security Number:				Medicaid Number:
Recipient Currently Resides in (Check one):	☐ Family Home	☐ Group Home	☐ Nursing Home	☐ Psychiatric Hospital
	☐ Development Center / ICF		☐ Psychiatric Residential Treatment Facility	
	Name of Facility (if applicable):			

Section II: Freedom of Choice		
I understand that I have a choice in accepting CSOC Services or placement in an institution. CSoC and institutional services have been explained to me.		
I would like to receive: (Check One)	☐ CSoC Waiver Services	☐ Institutional Services

Initials of Recipient/Legal Guardian or Custodian:	**Date:**

I understand that I have a choice of providers and between which services I may be eligible to receive. These services have been explained to me, and a listing of service providers in my area has been made available to me.

I have chosen the following provider(s) and service(s).

Provider:	**Service(s):**

Initials of Member/Legal Guardian or Custodian:	**Date:**

(FOC Form Revised 6/10/2019)

Member's Freedom of Choice (Continued)

Section III: Enrollee Rights & Reporting	
My Wraparound Facilitator helped me know what waiver services are available to me, and provided material for my review.	
Initials of Member/Legal Guardian or Custodian:	**Date:**

My Wraparound Facilitator gave me a copy of the Louisiana CSoC Member Handbook, which includes important information such as my rights and responsibilities, how to find providers, and how to file an appeal and grievance.	
Initials of Member/Legal Guardian or Custodian:	**Date:**

My Wraparound Facilitator helped me know how to report suspected abuse, neglect, extortion, exploitation, and death of adults and children and my right to be free from restraints, seclusion, and harm, and provided material for my review.	
Initials of Member/Legal Guardian or Custodian:	**Date:**

Section IV: Release of Information	
I permit the release of any and all information pertaining to my application for services, which may be in the possession of the Wraparound Agency (WAA), to Magellan Health Services of Louisiana. The release of information includes, but is not limited to, my individualized Plan of Care, progress notes, doctor's reports/evaluations, psychological reports/evaluations, medical/social/educational assessments, including those provided by schools, other agencies, and or organizations, including all third party information which may be in DHH's possession. In the event that this form is signed by the Department of Children and Family Services (DCFS), the information released is confidential pursuant to state and federal law including but not limited to Louisiana Revised Statute 46:56. The use of this information shall be limited to the purpose of providing behavioral health services to the above named child.	
Signature of Member/Legal Guardian or Custodian	**Date**
Relationship to the Recipient:	

(FOC Form Revised 6/10/2019)