AmeriHealth Caritas Florida

Consent for Voluntary Suspension of Authorized Services

Florida Statewide Medicaid Managed Care (SMMC) Program

Enrollee name:	Enrollee's Medicaid ID number:
Enrollee's date of birth:	Parent/Legal Guardian:
Enrollee's address:	

I understand the following services have been prescribed by my child's physician and authorized by AmeriHealth Caritas Florida from / / through / / .

Authorized services:

I understand that I do not have to accept all of the services authorized to receive, and it is my choice to decline, of these services for the current authorized dates and times.

I choose not to have the following services for for the following authorized dates and times.
Declined services:

I understand remain(s) authorized to receive the total services listed above for the current authorized dates and times. It is my choice to decline these services for only these dates and times listed above. I understand this choice will not be considered as a change in the need for these services when it is time to renew the services for future dates. I also understand I may change my mind at any time and may receive all of the authorized services during the remainder of the current authorized dates.

Enrollee* or Parent /Legal Guardian signature:	Date
Enrollee* or Parent /Legal Guardian printed name:	
Florida Medicaid Health Plan Representative signature:	Date
Florida Medicaid Health Plan Representative printed name:	

*An enrollee 18 years of age or older, acting as his or her own legal guardian.

Consent For Voluntary Suspension of Authorized Services
Florida Statewide Medicaid Managed Care (SMMC) Program

Instructions

1. Enrollee information

This form is for use only when an enrollee is receiving services and the enrollee (or parent or legal guardian) chooses to receive fewer services than are authorized for the enrollee by the Medicaid health plan. This consent ensures that the voluntary suspension will not be considered in approval of any future service needs.

Fill in the blanks with the enrollee's name, address, date of birth, Medicaid identification number, and parent or legal guardian if applicable. Except for signatures, print all written information added to the form. Health plan care coordinators may complete the form for the enrollee except for the enrollee/parent/legal guardian's signatures.

2. Authorized services

Add the dates, and times if applicable, for the current authorized services. For example:

- I understand the following services have been prescribed by my/my child's (circle one) physician and authorized by (Health Plan Name) from 05/02/2020 through 06/01/2020.

In the box labeled "Authorized Services," list the services authorized by the enrollee's health plan. For example:

- Private duty nursing services, eight hours per day, seven days a week.

3. Declined services

In the box labeled "Declined Services," list the authorized services being declined. Services may be declined in part or in total. Provide any information necessary to ensure the enrollee/parent/legal guardian's wishes are upheld. For example:

- Private duty nursing services each day on Saturday and Sunday for four hours from 8 a.m. to noon.
- Private duty nursing services from 05/17/2020 through 05/25/2020.

The enrollee/parent/legal guardian must be given the opportunity to review the form for correctness and allowed to revise the form as appropriate.

4. Signatures and dates

The health plan care coordinator and the enrollee/parent/legal guardian both must sign and date the consent form. If the consent is given during an in-person meeting, all signatures and dates should be completed at the meeting. If the consent is not in person, the health plan care coordinator may sign and date the consent on the day of consent and the enrollee/parent/legal guardian must sign and date the consent form at the next home visit.

5. Recordkeeping

Mail a copy of the signed and dated form to the enrollee/parent/legal guardian at the address provided on the form.

The health plan must keep the completed, signed form in the enrollee's record.

AmeriHealth Caritas Florida

Discrimination is against the law

AmeriHealth Caritas Florida complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently based on race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation.

AmeriHealth Caritas Florida:

- Provides free (no-cost) aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters.
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free (no-cost) language services to people whose primary language is not English, such as:
    - Qualified interpreters.
    - Information written in other languages.

If you need these services, contact AmeriHealth Caritas Florida at **1-855-355-9800 (TTY 1-855-358-5856)**. We are available 24 hours a day, seven days a week.

If you believe that AmeriHealth Caritas Florida has failed to provide these services or has discriminated against you in another way, you or your authorized representative (if we have your written authorization on file) can file a grievance with:

- Grievances and Appeals, P.O. Box 7368, London, KY 40742. Phone: **1-855-371-8078 (TTY 1-855-371-8079),** or Fax: **1-855-358-5847**.
- You can file a grievance by mail, fax, or phone. If you need help filing a grievance, AmeriHealth Caritas Florida Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (TTY 1-800-537-7697)

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html.

English: This information is available for free in other languages. Please contact our customer service number at **1-855-355-9800 (TTY 1-855-358-5856)**, 24 hours a day, seven days a week. If your primary language is not English, or to request auxiliary aids, assistance services are available to you, free of charge.

Spanish: Esta información está disponible en otros idiomas de forma gratuita. Póngase en contacto con nuestro número de servicios al cliente al **1-855-355-9800 (TTY 1-855-358-5856)**, las 24 horas del día, los siete días de la semana. Si su idioma principal no es el inglés, o necesita solicitar ayudas auxiliares, hay servicios de asistencia a su disposición de forma gratuita.

Haitian Creole: Enfòmasyon sa yo disponib gratis nan lòt lang. Tanpri kontakte ekip sèvis kliyan nou an nan **1-855-355-9800 (TTY 1-855-358-5856)**, 24 è sou 24, sèt jou sou sèt. Si anglè pa lang manman w oswa si w ta renmen mande yon èd konplemantè, ou ka resevwa sèvis ki gratis pou ede w.

Vietnamese: Thông tin này có sẵn miễn phí ở các ngôn ngữ khác. Vui lòng liên lạc bộ phận dịch vụ khách hàng của chúng tôi theo số **1-855-355-9800 (TTY 1-855-358-5856)**, 24 giờ một ngày, bảy ngày trong tuần. Nếu ngôn ngữ chính của quý vị không phải là tiếng Anh, hoặc để yêu cầu các thiết bị trợ giúp bổ sung, thì quý vị có thể sử dụng miễn phí các dịch vụ hỗ trợ.