MOLINA HEALTHCARE

FREEDOM OF CHOICE CERTIFICATION

FOR FLORIDA STATEWIDE MEDICAID MANAGED CARE (SMMC) PROGRAM

Enrollee Name: _____ **Authorized Representative[1]:** _____

Medicaid ID Number: _____ **Relationship to Enrollee** _____

Enrollee Date of Birth:

- Has the Enrollee or their Authorized Representative received information on the full complement of Medicaid services available to the enrollee, including any Medicaid home and community-based service options (if applicable)? ☐ Yes ☐ No

- If receiving services in a nursing facility, is the Enrollee or their Authorized Representative opposed to transitioning the enrollee to the community? ☐ Yes ☐ No If yes, explain:
  _____

FREEDOM OF CHOICE CERTIFICATION:

1. My signature on this form certifies that I have read this form, or the form has been read to me, and I understand the contents of this form. I understand that by signing this form, I agree with the choice checked below. I also understand that if I change my mind and want to make another choice, my plan case manager will provide me with another form to indicate my new choice.

2. My choice is indicated by the checked box.

   ☐ I want to receive services in the community.
   ☐ I want to live in a nursing facility (if assessed need exists).

I, _____ (*Enrollee/Authorized Representative)* agree to the case manager attesting to my choice specified on this form.

_____ _____
Enrollee/Authorized Representative Signature Date

_____
Enrollee/Authorized Representative Printed Name

Plan Case Manager Signature: _____ **Date: _____**

Plan Case Manager Printed Name: _____
_____

[1] *Authorized representative must be determined in compliance with applicable federal and state laws (including, but not limited to, 42 CFR Part 435, and Chapters 709, 744, and 765 of the Florida Statutes).*

NOTE: *The original certification form shall be completed and signed by the plan member (enrollee/ authorized representative) and maintained in the member's plan file.*

INSTRUCTIONS FOR FREEDOM OF CHOICE CERTIFICATION

Within seven (7) days of initial enrollment and at least annually thereafter, the plan case manager shall review the Freedom of Choice Certification with the plan member (enrollee) and obtain the enrollee's signature on the completed certification.

In the enrollee information panel at the top of the form, enter the enrollee's:

- First and last name in the Enrollee Name field;
- Medicaid Identification (ID) Number; and
- Date of Birth (DOB).

If the enrollee has an authorized representative, provide:

- Representative's first and last name in the Authorized Representative field; and
- Representative's relationship to the enrollee.

If the enrollee does not have an authorized representative, enter "N/A" in the Authorized Representative and Relationship to Enrollee fields.

Determine if enrollee or his or her authorized representative has:

- Received information about Medicaid services available to the enrollee in the community; or
- Any opposition to transitioning the enrollee to the community.

If the enrollee or authorized representative responds that information about Medicaid services available in the community has not been received, then review the descriptions of home and community-based services and options for receiving Medicaid services in the community (as applicable) with the enrollee before completing the Freedom of Choice Certification.

Request that the enrollee or authorized representative read and review the Freedom of Choice Certification and indicate enrollee choice for receiving Medicaid services.

Obtain the enrollee's or enrollee authorized representative's signature above his or her printed name.

After the enrollee/authorized representative agrees to allow the case manager to attest to the choice indicated by the enrollee/authorized representative, the plan case manager shall sign and date the certification form and place it in the plan member's (enrollee) file.

A copy of the completed and signed certification shall be provided to the enrollee/authorized representative via hand delivery or mail within five (5) business days of the date of certification.

Please note: If you have a disability and need more help, we can help you. If you need someone that speaks your language, we can also help. You may call our Member Services Department at (866) 472-4585 for more help from 8:00 am to 7:00 pm. If you are blind or have trouble hearing or communicating, please call 711 for TTY/TTD services. We can help you get the information you need in large print, audio (sound), and braille. We provide you with these services for free.

Tenga en cuenta lo siguiente: si tiene una discapacidad y necesita más ayuda, podemos ayudarlo. También podemos ayudarlo si necesita a alguien que hable en su idioma. Para obtener más ayuda, puede llamar a nuestro Departamento de Servicios para Miembros al (866) 472-4585, de 8:00 a. m. a 7:00 p. m. Si es ciego o tiene problemas de audición o comunicación, llame al 711 para acceder a servicios de TTY/TDD. Podemos ayudarlo a obtener la información que necesita en letra de molde grande, audio (sonido) y en sistema Braille. Estos servicios son gratuitos.

Remake: Si ou gen yon andikap epi ou bezwen plis èd, nou kapab ede w. Si ou bezwen yon moun ki pale lang ou an, nou kapab ede w tou. Ou gendwa rele Depatman Sèvis Manm nou an nan (866) 472-4585 pou jwenn plis èd soti 8è:00 a.m. rive 7è:00 p.m. Si ou avèg oswa ou gen difikilte pou tande oswa pou kominike, tanpri rele 711 pou sèvis TTY/TTD yo. Nou kapab ede w jwenn enfòmasyon oubezwen an gwo karaktè, odyo (son) ak an Bray. N ap ba w sèvis sa yo pou gratis.

Xin lưu ý: Nếu quý vị là người khuyết tật và cần thêm trợ giúp, chúng tôi có thể giúp quý vị. Nếu quý vị cần người có thể nói ngôn ngữ của quý vị, chúng tôi cũng có thể giúp. Quý vị có thể gọi cho Bộ phận Dịch vụ thành viên của chúng tôi theo số (866) 472-4585 để được trợ giúp thêm từ 8:00 am đến 7:00 pm. Nếu quý vị bị mù hoặc có vấn đề về thính giác hoặc giao tiếp, vui lòng gọi 711 cho dịch vụ TTY/TTD. Chúng tôi có thể giúp quý vị nhận thông tin quý vị cần bằng bảng chữ in lớn, âm thanh và chữ nổi Braille. Chúng tôi cung cấp miễn phí các dịch vụ này cho quý vị.

Non-Discrimination Notification

Molina Healthcare of Florida, Inc.

Medicaid

Discrimination is against the law. Molina Healthcare of Florida, Inc. (Molina) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Molina:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Molina Member Services at (866) 472-4585 (TTY: 711).

If you believe that Molina has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
200 Oceangate, Ste 100
Long Beach, CA 90802
Phone: (866) 472-4585 (TTY: 711)
Fax: (877) 508-5738
Email: **civil.rights@molinahealthcare.com**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Molina Member Services is available to help you. You may obtain our grievance procedure by visiting our website at: **https://www.molinahealthcare.com/members/common/en-US/Notice-of-Nondiscrimination.aspx**.

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
Phone: (800) 368-1019 (TDD: (800) 537-7697)

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

Non-Discrimination Tag Line – Section 1557

Molina Healthcare of Florida, Inc.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (866) 472-4585 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (866) 472-4585 (TTY: 711).
French Creole (Haitian Creole)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (866) 472-4585 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (866) 472-4585 (TTY: 711).
Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (866) 472-4585 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (866) 472-4585（TTY：711）。
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (866) 472-4585 (TTY : 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (866) 472-4585 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (866) 472-4585 (телетайп: 711).
Arabic	ةظوملحة: اذإ تكن ركذا ثدحتت غةللا، نإف تامدخ ةدعاسملا ةيوغللا رفاوتت نماجملاب كلا. لتصا مقرب (866) 472-4585 (مقر فتاه مصلا مكبلاو: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (866) 472-4585 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (866) 472-4585 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (866) 472-4585 (TTY: 711) 번으로 전화해 주십시오.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (866) 472-4585 (TTY: 711).
Gujarati	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (866) 472-4585 (TTY: 711).
Thai	เรยน: ถาคณพดภาษาไทยคณสามารถใชบรการชวยเหลอทางภาษาไดฟร โทร (866) 472-4585 (TTY: 711).

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