Financial Management Services Agency (FMSA) Transfer Form: Self-Directed Services

(To be completed by Person, Parent/Guardian, and Support Coordinator)

Waiver Participant Name:	Medicaid Number:	Authorization ID:	EIN#:
Support Coordination Representative:	Self-Directed Liaison:	HCBS Waiver:	
Employer of Record Name:	Date:	Region:	

Self-direction is designed to make service delivery as flexible as possible for individuals and their families, and to make sure individuals who self-direct can exercise maximum choice and control over their services and supports. Self-direction is a model of service delivery in which an individual has maximum choice and control over how, when, where, and from whom their services and supports are provided.

Please check Yes or No indicating your agreement with and acknowledgment of the following:			
1	I have received information regarding the option to self-direct my services as well as information for certified support service agencies.	YES	NO
2	I understand that I have the right to choose the provider for each of my HCBS Waiver services.	YES	NO
3	I have received and read ALLIED brochure for FMSA.	YES	NO
4	I have received and read Public Partnerships LLC (PPL) brochure for FMSA.	YES	NO
5	I understand my Roles and Responsibilities in receiving Self-Directed Services through each FMSA.	YES	NO
6	I am making a Voluntary Decision to transfer From _____To _____ Targeted Effective Date:_____		
7	I understand that the FMSA transfers are allowed only at the start of the quarter (January 1st, April 1st, July 1st, October 1st) and only once per year (due to federal tax regulations).	YES	NO

I understand that due to the transfer process the budgetary savings will not be accessible for 60-90 days. My signature below is my acknowledgement and agreement to transfer FMSA.

Waiver Participant Signature_____ Date_____

Employer of Record Signature_____ Date_____

ADMH Representative Signature_____ Date_____