



## ANNUAL ACKNOWLEDGEMENT OF PARTICIPATION IN SELF-DETERMINATION

Name: \_\_\_\_\_  
Member OCHN CONID Number: \_\_\_\_\_

### SELF-DETERMINATION

I understand that the services and supports provided through Oakland Community Health Network (OCHN) for myself or on behalf of the person named above are provided using arrangements that support self-determination. The principles of self-determination are outlined in the Oakland Community Health Network Self-Determination Policy. The roles and responsibilities of the various parties are outlined in the Self-Determination Agreement.

### CHOICE OF PROVIDERS

I understand that I have a choice of service providers for all services authorized in my Individual Plan of Service. OCHN maintains a network of qualified providers. Providers are deemed qualified by successful completion of a credentialing process (and where applicable, contracting process). If a person identifies a non-credentialed organization or person for a Medicaid-covered authorized service, Oakland Community Health Network (OCHN) may consider that organization or person for possible credentialing so long as they are willing and able to meet the expectations set forth in the credentialing and contracting process.

\_\_\_\_\_  
Applicant/Legal Representative's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\*\*\*Support Coordinator\*\*\*

By signing this document, I, \_\_\_\_\_, have reviewed the Self-Determination Agreements pertaining to their Self-Determination arrangement with the individual/guardian/family served and ensured understanding of the material.

\_\_\_\_\_  
Support Coordinator's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\*\*\*Internal Review Only\*\*\*

\_\_\_\_\_  
MCA Reviewer Name

\_\_\_\_\_  
Review Date