

Name: _____

CON ID: _____



ANNUAL ACKNOWLEDGEMENT OF PARTICIPATION IN SELF-DETERMINATION

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 the person served/guardian have indicated that they understand the material and information presented.

Support Coordinator's Signature

Printed Name

Date

Internal Review Only

MCA Reviewer Name

Review Date