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MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
HABILITATION SUPPORTS WAIVER (HSW) ELIGIBILITY CERTIFICATION

PRIORITY PROCESSING: ☐ Age off CWP (age 18) ☐ Age-off State Plan PDN (age 21) ☐ At imminent risk of ICF/IID (referral from CPLS)

SECTION 1

Initial Certification ☐	Annual Recertification ☐		Next Recertification Due Date:
Last Name	First Name	Medicaid # *MUST be 10-digits – include leading zeros*	Consumer Unique Id
Address		City/ Zip	Date Of Birth
DHS License # For Residence (If Applicable)		Prepaid Inpatient Health Plan	County Of Financial Responsibility
# Of Licensed Beds At Residence	Self-Determination Arrangement	Enrolled In MI Choice	Medicaid Eligible / Date Medicaid Eligibility Verified

This is to certify that the above named individual is eligible for Medicaid coverage and has received a comprehensive evaluation of his/her needs. The comprehensive evaluation and supporting documentation are available in the individual's record.

_____ _____ _____

Support Coordinator Signature & Credentials | Date | Other PIHP Staff (Optional) | Date

SECTION 2

Based on the results of the comprehensive evaluation and supporting documentation, the following Waiver eligibility requirements are met:

☐ This individual has a developmental disability as defined in the Developmental Disabilities Assistance and Bill of Rights Act (P.L.106-402).

☐ If not for the availability of home and community-based services, this individual would require the level of care provided in an intermediate care facilities for Individuals with Intellectual Disabilities (ICF/IID).

☐ WAIVER RECOMMENDED

☐ WAIVER NOT RECOMMENDED

_____ _____ _____

QIDP Signature & Credentials | Date | PIHP Designee (Optional) | Date

SECTION 3

Previous Consent Expires: _____

I understand that I may accept or reject waiver services instead of services provided in an ICF/IID and that I may withdraw this consent at any time in writing. This consent may not exceed 36 months. I ☐ accept ☐ reject services as offered under the Habilitation Supports Waiver (HSW).

_____

Signature Date

☐ Self ☐ Legal Guardian or Parent of minor
☐ Telephone Consent Obtained (attach written consent)

_____

Witness (required only if signature above made by a mark) Date

SECTION 4

WAIVER ENROLLMENT:

☐ ENROLLED or ☐ RECERTIFIED EFFECTIVE DATE: _____

☐ NOT ELIGIBLE or ☐ DISENROLLED REASON: _____

IF Disenrolled, Notice of Right to Fair Hearing: Date: _____

_____ _____

PIHP Designee Signature (for recertifications and disenrollments) or MDHHS Signature (for new enrollments) Date