New Choices Waiver
Bureau of Authorization and Community Based Services, Division of Medicaid and Health Financing
801-538-6155 (option 6) or toll free 800-662-9651 (option 6)

Freedom of Choice Consent Form – Summit County

☐ New Applicant ☐ Transfer Request/New CMA Selection

Individual's Name: _____ DOB: _____

As a New Choices Waiver client wishing to transfer to a new case management agency you or your chosen representative will need to select a case management agency that is different from your previous choice. This form is designed to help in that selection process. This form should never be completed without your involvement, nor should it ever reflect a choice that you did not make of your own free will. If you experience any undue influence, please call the New Choices Waiver Program Office to inform us of the incident and to express your actual choice of case management providers. (800-662-9651, option 6)

You are free to choose from the list of all case management agencies that are available in your area. Which case management agency would you like?

☐ Envision Quality Supports	☐ Adult Case Management	☐ FlexCare
☐ Care Advocates	☐ Utah Case Management	☐ Advocates for Independence
☐ De Novo Services	☐ Mountainland AOG	☐ Abundant Solutions

Referrals to case management agencies can only be made by the New Choices Waiver Program Office. Once you have made your selection above, please fax this form to: (801)323-1586

When the completed form is received, the New Choices Waiver Program Office will send a referral packet to the case management agency that you have chosen. To facilitate a smooth transition and to ensure continuity of care, the referral packet will consist of the original application forms and medical records that you submitted when you initially applied to the New Choices Waiver program and will also include any relevant New Choices Waiver records that we have received from case management agencies or other New Choices Waiver providers since your initial application. This may include but is not limited to notice of decision letters, medical eligibility assessment information, person-centered care plans, incident reports, health and safety agreements and case management log notes.

By signing below, I certify that I have selected this case management agency of my own free will. I also certify that I have read and understand the information contained in this form and I authorize the New Choices Waiver Program Office to release a referral packet as described above to the case management agency that I have selected.

_____ _____
Signature Date

Who is signing? ☐ Self/Applicant ☐ Family Representative ☐ Legal Representative

Representative's Name (Print): _____

Representative's Authority: _____

Phone number for me or my representative: _____