Children and Youth Evaluation Service
Your Connection to Home and Community-Based Services

1-833-333-CYES
(1-833-333-2937)
TTY: 1-888-329-1541

HEALTH HOME OPT-OUT FORM

- Use this form to decline Health Home care management services.
- Children/youth who are 18 years old or older or who are pregnant or a parent and /or married can complete and sign this form.
- All other children/youth must have this form completed and signed by their parents, legal guardians, caregivers or legally authorized representatives.

PART 1 Child/Youth Contact Information

Tell us about the child/youth who is declining or no longer wants Health Home care management services. Please print.

Child or youth first name: _____ Middle initial: _____ Last name:_____

Home address: _____

City: _____ State: _____ ZIP Code: ___ ___ ___ ___ ___

Date of Birth: ___ ___ /___ ___ / ___ ___ ___ ___
M M D D Y Y Y Y

Gender: ❑ Male ❑ Female ❑ Other Gender expression: _____

Social Security Number (SSN):
___ ___ ___ - ___ ___ -___ ___ ___ ___

Client Identification Number (CIN):
___ ___ ___ ___ ___ ___ ___ ___

PART 2 Parent, Legal Guardian, Caregiver or Legally Authorized Representative Contact Information

The parent, legal guardian, caregiver or legally authorized representative must complete this information for the child/youth who is under 18 years old, and is not pregnant, a parent and or married. Please print.

First name: _____ Middle initial: _____ Last name:_____

Are you the primary contact? ❑ Yes ❑ No

Check one: ❑ Parent ❑ Legal guardian ❑ Caregiver ❑ Legally authorized representative

Home address: _____

City: _____ State: _____ ZIP Code: ___ ___ ___ ___ ___

Primary language: _____ Email address:_____

Home number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Work number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Cell number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Can we send you text messages? ❑ Yes ❑ No

Continued on the next page ⇨

If you have questions about this form, call CYES at 1-833-333-CYES (1-833-333-2937) TTY: 1-888-329-1541

Monday to Friday, from 8:30 am to 5:30 pm
Saturday, from 9:00 am to 12:00 pm

_____

CHILD/YOUTH'S NAME

PART 3 Attestation

The child or youth's parent, legal guardian, caregiver or legally authorized representative must fill in this part if completed Part 2.

❑ The care coordination services the child/youth can get from a Health Home care manager and the Health Home program have been explained to me. We have decided **not** to participate at this time.

If you are opting out for yourself, please fill in this information.

❑ The care coordination services I can get from a Health Home care manager and the Health Home program have been explained to me. I have decided **not** to participate at this time.

PART 4 Reason for Opting Out

Give the reason for opting out or declining Health Home care management services.

_____

_____

_____

_____

_____

_____

_____

_____

SIGNATURE

I understand that by signing this form I am requesting C-YES to provide HCBS care coordination.

_____

Name of member or child or youth's parent, legal guardian, caregiver, legally authorized representative (Print)

_____ _____

Signature: Date

QUESTIONS?

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