



Health Home Opt-Out Form

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

- 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 want 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: ____/____/____

MM DD YYYY

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 are under 18 years old, and are 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

Part 2 continued on the next page →

QUESTIONS? 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

Part 2 (continued)

Home address: _____

City: _____ State: _____ ZIP Code: _____

Primary language: _____ Email address: _____

Home number: (____) _____ - _____ Work number (____) _____ - _____

Cell number: (____) _____ - _____ Can we send you text messages? Yes No

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 my child 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

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