



DIVISION OF MEDICAID
BUREAU OF MENTAL HEALTH PROGRAMS

MYPAC FREEDOM OF CHOICE
SELECTION FORM
DOM Fax: (601) 359-6294



Participant Name

MID

Section 1902(a) (23) of the Social Security Act says that all Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. As a Medicaid beneficiary, you also have the right to choose how you will get services. You can choose to get these services in one of two ways; psychiatric residential treatment facilities (PRTF) or in the MYPAC community-based program. The MYPAC program is a demonstration program. If you choose MYPAC, you must take part in a National Evaluation (Study). The Study is to find out if youth can get mental health services in their homes and communities instead of going to a PRTF and keep up or make better their level of functioning. The Study will also find out if MYPAC is cost-effective.

Check the box next to the type of service you want. If you do not want MYPAC services, please check that box.

- Psychiatric Residential Treatment Facility (PRTF)
MYPAC Community-based Demonstration Program with Participation in the Study
Do not want MYPAC services

If you chose MYPAC, please look at the following list of MYPAC Primary Service Coordinators who will offer Mississippi Division of Medicaid MYPAC waiver services.

Check the box next to the Primary Services Coordinator that you want. If you do not have a choice, please check the box next to "No Choice". A Primary Service Coordinator will be picked for you.

- Mississippi Children's Home Society
Youth Villages
Pine Belt Mental Healthcare Resources - Transitional Age Group (TAG)
Serving youth 18-21 in the following counties: Covington, Forrest, Greene, Jefferson Davis, Jones, Lamar, Marion, Perry and Wayne
No Choice

I agree to this screening process. I have had program choices explained to me. I have made my choice by marking a check in the correct boxes above. I understand that the Medicaid program has clinical and financial eligibility requirements that are not a part of this screening. I give the okay to the agency or the attending doctor to give DOM the information needed to meet the federal requirements to look at and/or help me in getting services.

SIGNATURE

DATE

PRINTED NAME