

**MSC+/MSHO Institutional Support Plan Signature Page**

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| **MY SIGNATURE** |
| Yes No I have been given a choice of different types of services that can meet my needs, as seen on my plan. |
| Yes No I have been offered a choice of providers from available providers. |
| Yes No I have annually received my appeal rights. |
| Yes No I am aware that healthcare information about me will be kept private. |
| Yes No I have discussed my plan of care with my care coordinator and have chosen the services that I want. |
| Yes No I agree with the plan of care as discussed with my care coordinator. |

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| Support Plan Mailed/Given to Me On: | Support Plan Mailed/Given to My Doctor (verbal, phone, fax, EMR): |
| My Signature/My Representative Signature: | Date: |
| Care Coordinator Signature and Credentials: | Date: |

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| Member Name: | Health Plan I.D. Number: |