

**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:      |