New York State Department of Health
Medicaid

Health Home Opt-out Form

Attestation Statement

For use by Health Home eligible Medicaid client

☐ I have met with the Health Home care manager for _____
Name of Health Home

who has explained the Health Home program to me and the Health Home care management services I can get. I have decided not to join the Health Home program at this time.

For use by Health Home care manager

☐ I have discussed the Health Home program with _____
Name of Medicaid Client

over the telephone. The benefits of Health Home services were explained; however, the Medicaid client has decided not to join at this time.

Reason for Opting Out

_____

_____

Signatures

I understand that I will not get a Health Home care manager or Health Home services. I understand that if I am eligible for Office for People With Developmental Disabilities' (OPWDD) Home and Community Based Services (HCBS) and I have opted out of Health Home services, I will need to enroll in an alternate form of care management in order to receive HCBS services.

Name of Medicaid Client (print)	Original Signature of Medicaid Client	Date
Name of Medicaid Client's Parent, Guardian, or Legally Authorized Representative, if applicable (print)	Original Signature of Medicaid Client's Parent, Guardian, or Legally Authorized Representative, if applicable (print)	Date
Name of Health Home Care Manager (print)	Original Signature of Health Home Care Manager	Date

NOTE

If you would ever like to get Health Home services contact the NYS Medicaid Program by calling the Medicaid Call Center at 1-800-541-2831.