Health Home Opt-out Form

Attestation Statement		
For use by Health Home eligible Medicaid client		
I have met with the care manager for Name of Healt	h Home	
who has explained the program to me and the car	re management services I can get. I	have decided not to join at this time.
For use by care manager		
I have discussed Name of Health Home		
program withName of Medicaid Member		over the telephone. The benefits of
name of Medicald Member membership were explained; however, the Medic	aid client has decided not to join at	this time.
Reason for Opting Out		
Signatures		
I understand that I will not get a care manager or Hea services.	lth Home services, but I will still co	ntinue to get my Medicaid health care
Name of Member or Client's Legal Representative (print)	Original Signature	Date
Name of Health Home Care Manager (print)	Original Signature	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.