Medicaid Freedom of Choice (FOC) List

For Waiver Services

PROVIDER REQUEST

Please Check One: ☐ New FOC Request ☐ Update existing FOC information

☐ Notification of Agency Closure or Service Termination: Enter Effective Date:

Please Print/Type ALL Information Requested:

Current Information	Previous Information
Provider Name:	**Former Name:**
Provider Address(Include City, State, Zip):	**Former Address:**
Provider Contact Name &	**Former Provider Contact Name &**
Provider Phone - Fax Number(s) (Include area code): **Phone :** **Fax:**	**Previous Provider Phone - Fax Number(s) (Include area code):** **Phone:** **Fax:**
Provider Toll-Free Phone Number:	**Former Provider Toll Free Phone Number:**
Provider E-Mail	**Former Provider E-Mail**

Please place/update/remove the above named agency on/from the Freedom of Choice list for the provider type(s) checked below.

☐	03	Children's Choice (Children's Choice Waiver)	Region(s):
☐	06	Professional Services [NOW] Check all applicable services: ☐ Psychologist ☐ Social Worker ☐ Nutritional/Dietary	Region(s):
☐	11	Shared Living (ROW)	Region(s):
☐	13	Pre Vocational	Region(s):
☐	14	Day Habilitation	Region(s):
☐	15	Environmental Modifications	Region(s):
☐	16	Personal Emergency Response System (PERS)	Region(s):
☐	17	Medical Equipment and Supplies (Assistive Devices)	Region(s):
☐	31	Psychologist (ROW)	Region(s):
☐	35	Physical Therapist ☐ CC ☐ ROW ☐ Both CC and ROW	Region(s):
☐	37	Occupational Therapist ☐ CC ☐ ROW ☐ Both CC and ROW	Region(s):
☐	39	Speech Therapist ☐ CC ☐ ROW ☐ Both CC and ROW	Region(s):
☐	41	Registered Dietician (ROW)	Region(s):
☐	44	Skilled Nursing (NOW)	Region(s):
☐	73	Social Worker (ROW)	Region(s):
☐	82	Personal Care Attendant (PCA): ☐ CC/NOW/SW ☐ ROW	Region(s):
		Check one if ROW is selected above: ☐ Community Living Supports ☐ Companion Care Support ☐ Both CLS and CCS	
☐	83	Center-Based Respite	Region(s):
☐	84	Substitute Family Care: ☐ NOW ☐ ROW	Region(s):
☐	85	ROW Adult Day Health Care (ADHC)	Region(s):
☐	89	Supervised Independent Living (SIL) – (NOW)	Region(s):
☐	98	Supported Employment	Region(s):

Provider's Signature and Title: **Date:**

It is the **Provider's Responsibility** to notify the Louisiana Department of Health (LDH), Waiver Supports and Services, regarding any changes in the above noted information within ten (10) days of any changes. To keep from being removed from the FOC list, a provider's license and enrollment must be kept current. This notice will **NOT** notify DXC Provider Enrollment or Licensing regarding these changes.

The following must be included with all submissions:

Completed 1.) FOC Form, 2.) A **copy** of your current license, and 3.) A **copy** of your current Medicaid Provider Enrollment Letter(s)

Mail or Fax to:

OCDD/Waiver Supports & Services
628 North 4th Street, 2nd Floor
Baton Rouge, LA 70802
Fax: (225) 342-8823

Reissued: 05/07/2019

Replaces all previous issuances