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 (Please document as it is or should appear on FOC)	**Previous Information (Please only complete if there was a change/update)**
Provider Name:	**Former Name:**
Provider Address(Include City, State, Zip):	**Former Address:**
Provider Contact Name & Title:	**Former Provider Contact Name & Title:**
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 Address:	**Former Provider E-Mail Address:**

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 (ROW)	Region(s):	
☐	37	Occupational Therapist (ROW)	Region(s):	
☐	39	Speech Therapist (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):	
☐	83	Center-Based Respite	Region(s):	
☐	84	Substitute Family Care: ☐ NOW ☐ ROW	Region(s):	
☐	89	Supervised Independent Living (SIL) – (NOW)	Region(s):	
☐	98	Supported Employment	Region(s):	

Provider's Signature & Title:

Date:

It is the **Provider's Responsibility** to notify the Louisiana Department of Health and Hospitals (DHH), 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 Molina Provider Enrollment or Licensing regarding these changes.

The following must be included with all submissions:

Completed FOC Form, 2.) A **copy** of your current license, and 3.) A **copy** of you 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

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Replaces all previous issuances