Sample SC FOC: Region number and list of available SC Agencies will vary from region to region.

SUPPORT COORDINATION CHOICE and RELEASE OF INFORMATION FORM
EPSDT Target Population DHH Region 2

To the recipient: Please fill out Sections 1, 2 and 3 of this form and return it as soon as possible to:

Statistical Resources, Inc. Case Management
11505 Perkins Road, Suite H
Baton Rouge, Louisiana 70810
Fax: (225) 767-0502

Recipient's Name: _____ Date of Birth: _____

Physical Address: _____ City: _____

State: _____ Zip code: _____Telephone Number: (_____) _____-_____

Social Security Number: _____-____-_____ Medicaid Number: _____

Population: ☐ EPSDT Targeted Case Management

Recipient currently resides in a Group Home, Developmental Center, or Nursing Home? ☐ Yes ☐ No

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Section 1: Support Coordination Freedom of Choice - DHH Region 2

The state has contracted with several support coordination providers in your area. Included with this letter are brochures describing the services of each agency.Please choose a provider from among these agencies. We ask that you number your choices.Please write 1 (one) in the box by your first choice and write 2 (two) in the box by your second choice.If your first choice is full, you will be linked to your second choice if they are not full.You will be linked for a 6-month period, after which you have the option of changing agencies if space is available.

[ ] Medical Resources & Guidance
[ ] Community Resource Coordinators

_____ _____
Signature of Recipient / Legal Guardian Date

Section 2: Release of Information

I permit the release of any and all information which may be in the possession of DHH offices that pertain to my application(s) for services, including but not limited to OCDD statement of eligibility, OCDD Request for Services list, plans of support, generic service plans, doctor's reports/evaluations, psychological reports/evaluations, medical/social/educational assessments of any kind, including those provided by schools, other agencies, and /or organizations. This includes all third party information which may be in DHH's possession..

_____ _____
Signature of Recipient / Legal Guardian Date

Section 3: Transfer of Records (For Agency Use Only)

Indicate which of the required documents have been transferred from the following agency: _____

☐ 1. Discharge 148	☐ 4. 51NH	☐ 7. Waiver slot letter (if not certified)	☐ 10. Medical Documentation	☐ 13. _____
☐ 2. Form 142	☐ 5. CPOC (current & approved)	☐ 8. Social Evaluation	☐ 11. IEP	☐ 14. _____
☐ 3. 18 LTC	☐ 6. Six months progress notes	☐ 9. Psych. Evaluation	☐ 12. _____	☐ 15. _____

Signatures by both Transferring Agency and Receiving Agency are required for the Transfer of Records to be finalized.

_____ _____
Transferring Agency (Signature Required) Date Receiving Agency (Signature Required) Date

STATISTICAL RESOURCES, INC. DOES NOT VERIFY MEDICAID ELIGIBILITY NOR DETERMINE IF THE RECIPIENT MEETS THE CRITERIA OF THE TARGET POPULATION. IT IS THE RESPONSIBILITY OF THE PROVIDER TO ENSURE ELIGIBILITY.