STATE OF MICHIGAN
Department of Health and Human Services
Aging and Adult Services

ENTER ADDRESSEE NAME
ENTER ADDRESSEE CARE OF
ENTER ADDRESSEE PO BOX OR STREET
ENTER ADDRESSEE CITY/STATE/ZIP

DHS-390, ADULT SERVICES APPLICATION

(Revised 9-25)

Complete the CLIENT INFORMATION, SECTION 3, and SECTION 4, and sign and date the second page. Return the first and second pages of this Adult Services Application using the enclosed business reply envelope.

Note: If you need help to complete this application, please indicate what kind of help you need.

☐ Bilingual Interpreter ☐ Sign-language interpreter for the deaf

☐ Other (specify)

SECTION 1 – FOR DEPARTMENTAL USE ONLY

1. Case Name | 2. Log Number | 3. Recipient Identification (ID) Number

4. County | 5. Date

6. Worker Name | 7. Worker Phone Number

SECTION 2 – CLIENT INFORMATION

8. Full Name of Person Needing or Requesting Services

9. Date of Birth (MM-DD-YYYY) | 10. Medicaid/Recipient ID

11. Street Address | City | State | Zip Code

12. Phone Number | 13. TTY Number (Teletype for the deaf) | 14. Email Address

SECTION 3 – DEPARTMENT PROGRAMS

1. ☐ Home Help
   Services to help pay for someone to assist with personal care and housekeeping.
2. ☐ Adult Community Placement
   Services for adults who can no longer remain in their own homes. Includes help finding an adult foster care home or home for the aged and services for people living in these settings.
3. ☐ Other Services
   Non-payment services to help adults stay safe in their own homes. Services may include information and referral to other community resources.

IF YOU OR SOMEONE YOU KNOW IS IN NEED OF PROTECTIVE SERVICES, CONTACT CENTRALIZED INTAKE FOR ABUSE, NEGLECT OR EXPLOITATION AT 855-444-3911.

SECTION 4 – CURRENT SITUATION

1. Your status as a recipient
   a. ☐ Medicaid (MA) recipient
   b. ☐ Medicaid application pending
   c. ☐ Supplemental Security Income (SSI) recipient
   d. ☐ MI Choice Waiver recipient
   e. ☐ PACE recipient
   f. ☐ MI Health Link recipient
   g. ☐ Community Mental Health (CMH) recipient
   h. ☐ Food Assistance recipient
   i. ☐ Family Independence Program (FIP) recipient
   j. ☐ State Disability Assistance (SDA) recipient
   k. ☐ Veteran Affairs recipient
   l. ☐ Other
2. Living Arrangement (Select all boxes that apply to you and answer related questions)
   a. ☐ Alone
   b. ☐ With spouse (if married answer questions below)
      Is spouse disabled? ☐ Yes ☐ No
      Is spouse working? ☐ Yes ☐ No
      Full name of spouse
   c. ☐ With children under age 18. How many?
   d. ☐ With others (relatives and non-relatives) How many?
   e. ☐ Live in adult foster care facility, home for the aged
   f. Is client in a hospital or nursing home? ☐ Yes ☐ No
   g. Do you have a guardian? ☐ Yes ☐ No
      Name of guardian
   h. Is a caregiver/provider already identified? ☐ Yes ☐ No

Read the following statement, sign, and date the application.

I wish to apply for one of the adult services programs. I certify that the information I have given is correct. By signing, I acknowledge that I have read and agree to the rights, responsibilities, and important things to know described in Section 5 of this application.

Client Signature →	Date

SECTION 5 – SERVICES APPLICATION RIGHTS, RESPONSIBILITIES, AND IMPORTANT THINGS TO KNOW

Instructions:

- Be sure to read this information. It describes your rights and responsibilities.
- **Keep this copy for your records.**
- If you have any questions regarding your rights and responsibilities or any information provided in this section, contact the adult services worker.

1. YOU HAVE THE FOLLOWING RIGHTS:

   Application: You have the right to apply for adult services programs at any time. Your application must be approved or denied within 45 days from the day your referral is received by MDHHS. When applying for Medicaid funded programs such as Home Help, you will not be approved until you have active Medicaid. If you need financial or medical assistance, another application is needed. You have the right to be notified in writing of the approval or denial of services and to be treated fairly and with dignity in all dealings with the department.

   Non-discrimination: If you believe you have been discriminated against because of race, sex, religion, age, national origin, color, height, weight, familial status, gender identification or expression, sexual orientation, partisan considerations, or disability or genetic information that is unrelated to the person's eligibility, you have the right to file a complaint with the following:

   - Michigan Department of Civil Rights: 800-482-3604
   - U.S. Department of Health and Human Services: 202-619-0403

   Hearings: If you believe you have been treated unfairly or a mistake has been made concerning your case, you have a right to request an administrative hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR) within 90 days of the action. You will be given the opportunity to explain your case to an impartial administrative law judge. You may request a hearing in any written form or you may submit the DCH-0092, Request for Hearing form, which is available online at https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448-16825--,00.html.

   All requests must be signed and dated by you or your authorized representative.

   Voter Registration: If you are not registered to vote, you have the right to register.

   Explanation About the Food Assistance Program (FAP):

   - You may be eligible to receive food benefits.
   - You may apply for the Food Assistance Program at your local MDHHS office. If you have questions, contact the Eligibility Specialist assigned to your Medicaid case

2. **YOU HAVE THE FOLLOWING RESPONSIBILITIES:**

   - You must provide MDHHS with correct and complete information about your situation. The information you give may need to be verified.
   - You must report any changes regarding your case to your adult services worker **within ten business days** of the change. This includes, but is not limited to, changes in your medical condition or care needs, living arrangements, familial status, change in providers, hospitalizations or nursing home stays (services cannot be paid while you are in the hospital or nursing home) or any other change which may affect your eligibility or the amount of benefits.
   - If you neglect or refuse to report required changes, or make false or misleading statements, you can be prosecuted for fraud. If you have any doubt about whether you should report a change, contact your adult services worker at the local MDHHS office.

Repayment of Benefits: I understand that if benefits are overpaid for any reason, the overpayment amount received will have to be repaid. In addition, if intentional misrepresentation or concealment of material information caused the overpayment, the responsible party/parties, including the provider of care, may be prosecuted for fraud.

Release of Information: I authorize the MDHHS to provide notice to my care provider(s) when Home Help services or Adult Community Placement has been authorized, when there are changes in the authorization amount previously given to the provider or when my case is closed.

3. **IMPORTANT THINGS TO KNOW:**

   a. Home Help and Adult Community Placement are Medicaid funded programs. As a Home Help recipient, I am responsible for any costs not paid by MDHHS, including benefits which may have been authorized but for which I no longer qualify due to Medicaid ineligibility. Adult Foster Care/Home for the Aged providers are responsible for returning supplemental payments they receive when a client is not eligible.

   b. I am not eligible for Home Help services prior to being certified by a Medicaid medical professional. Certification of need is provided on the MDHHS-6200 Adult Services Medical Needs Certification form.

   c. I understand that my Home Help provider must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS) and undergo a criminal history screening. Payment will only be made to the provider who is enrolled and approved by MDHHS to provide services for me. Adult Foster Care/Homes for the Aged providers must register in the Statewide Integrated Governmental Management Application (SIGMA) and enrolled in the Bridges system to receive payment.

   d. Payment for Home Help services cannot be approved prior to (1) the medical professional's signature date on the MDHHS-6200 and (2) the provider enrollment and approval date.

   e. I understand that my Home Help or Adult Community Placement case will be reviewed every six months to determine if I continue to qualify for services.

   f. I have the right to choose my Home Help provider. I understand that my provider is not employed by the State of Michigan or MDHHS. I am considered the employer and have the right to hire or fire my provider.

   g. I understand that Home Help services and Adult Community Placement are benefits to me and earnings to my provider. Home Help checks may be addressed to both the client and provider (dual party). I am responsible to endorse the check and give it to my provider. If I hire an agency or reside in an adult foster care home, checks will be sent directly to the agency on my behalf.

   h. I understand that ACP payments cannot be approved for periods of time that I am in a hospital, nursing home or rehabilitation facility as this is considered duplication of Medicaid services. Payment can be approved for services provided on the day I am discharged from the hospital, nursing home or rehabilitation facility but not the day I am admitted.

   i. I understand Home Help payments cannot be approved for periods of time that I am in a hospital, nursing home or rehabilitation facility as this is considered duplication of Medicaid services. Payment can be approved for services provided on the day I am discharged from the hospital, nursing home or rehabilitation facility. Payment may also be approved for services on the day I am admitted to a hospital if the services are provided before admission.

   j. If a reported change results in a reduction or termination of benefits, I will be notified in writing of the negative action.

   k. I understand that my individual Home Help provider must record the tasks they provide for me electronically in CHAMPS. An exception may be granted for my provider to submit a paper services verification if they meet certain criteria.

Michigan Department of Health and Human Services (MDHHS)
Please note if needed, free language assistance services are available.
Call 517-284-1018 (TTY 711).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 517-284-1018 (TTY 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 517-284-1018 (رقم هاتف الصم والبكم: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 517-284-1018 （TTY 711）
Syriac (Assyrian)	ܙܘܗܪܐ: ܐܢ ܐܚܬܘܢ ܟܐ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ ܕܦܠܚܝܬܘܢ ܚܠܡܬܐ ܕܥܘܕܪܢܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 517-284-1018 (TTY 711)
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 517-284-1018 (TTY 711).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 517-284-1018 (TTY 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 517-284-1018 (TTY 711)번으로 전화해 주십시오.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ 517-284-1018 (TTY ১ 711).
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 517-284-1018 (TTY 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 517-284-1018 (TTY 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 517-284-1018 (TTY 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。517-284-1018（TTY 711）まで、お電話にてご連絡ください
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 517-284-1018 (телетайп 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 517-284-1018 (TTY Telefon za osobe sa oštećenim govorom ili sluhom 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 517-284-1018 (TTY 711).

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Section 1557 Coordinator. The contact information is found below.

If you believe that MDHHS has not provided the above services, or discriminated in another way, you can file a grievance with the Section 1557 Coordinator. You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
Compliance Office, Suite 411
PO Box 30037
Lansing, MI 48909

517-284-1018 (Main), (TTY number—if covered entity has one), 517-335-6146 (Fax), MDHHS-Section-1557@michigan.gov (Email).

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD) Complaint forms are available at https://bit.ly/2IKsHMS.	If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by: Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.