

**PATIENT/FAMILY RIGHTS AND RESPONSIBILITIES**

**Patient and/or Family Responsibilities:**

These are the responsibilities of all Children Medical Services (CMS) program participants.

I, \_\_\_\_\_, being a CMS  Parent,  Legal Representative of Patient,  Patient age 18 or older, understand and agree to the following:

1. I will keep appointments at CMS clinics, doctor's offices, labs, etc., scheduled by CMS. If I am unable to do so, I will notify CMS 24 hours before the day of the appointment.
2. I will follow the doctor's treatment plan, or notify CMS if I am unable to do so.
3. I will notify CMS of any changes in my income. If my family income is greater than 150% Federal Poverty Level, I will share in the cost of medical expenses as per CMS guidelines.
4. I agree to notify CMS of any health insurance which covers the sponsored condition. All insurance benefits available, whether paid to me or the vendor, will be applied to the cost of care provided by CMS.
5. I will notify CMS of any changes in my address, phone number, email address and health care insurance information, including but not limited to Medicaid, PeachCare for Kids®, and private insurance coverage.
6. I will apply for Medicaid and/or PeachCare for Kids® if potentially eligible for coverage and submit all documentation required for enrollment.
7. I understand that CMS is not obligated to pay for any services, including but not limited to lab tests, doctor's visits, x-rays, or medications unless CMS has given prior written approval for the service. I understand that if I make any arrangements without approval by CMS, CMS will not pay for that service. I will contact CMS to report provider recommendations after each office visit.
8. I will notify CMS on the next working day if I must seek urgent medical care during non-CMS office hours, including night, weekends, and holidays for any CMS eligible condition. If CMS is not notified within the required time frame set forth above and service authorization not received, all expenses associated with ER/urgent care center visits and resulting hospital admissions are subject to a \$2,000 cap for reimbursement.
9. I understand that I am responsible for the proper care of any equipment such as wheelchairs or hearing aids obtained through CMS. CMS does not replace abused or lost equipment. If I outgrow or no longer need CMS provided equipment, my district CMS program may request that I return the equipment.
10. I, the parent/legal representative, will accompany any child under 18 years old to the office, clinic, or hospital.
11. I authorize the CMS program to obtain reports of previous treatment from hospitals, clinics, and physicians.
12. I understand that I can notify CMS and withdraw myself/my child from enrollment in the CMS program at any time.
13. I understand that if I do not comply with CMS program guidelines, I/my child may be dis-enrolled from the CMS program.
14. I am legally able to give consent for <patient name> to receive services from the CMS program and do hereby consent for <patient name> to be enrolled in the CMS program.

**Patient and/or Family Rights:**

These are the rights of all Children Medical Services (CMS) program participants.

1. Access to care for children and youth with special needs.
2. Access to family support.
3. Appropriate level of Care Coordination services.
4. Quality services are provided in a timely and cost-effective manner.
5. Access to appeals process.
6. Assistance in learning how to access needed services
7. Assistance with youth transition to adult care.

Patient/Legal Representative (signature)	Patient/Legal Representative (print)	Date
CMS Representative (signature)	CMS Representative (print)	Date

If you have any questions regarding the CMS program or this form, please call the CMS office at \_\_\_\_\_.

Patient's Name \_\_\_\_\_ Patient CMS ID No. \_\_\_\_\_