Department of Human Services
Med-QUEST Division

Community Integration Services Plus (CIS+) – Consent

(Appendix C)

First Name	Last Name	DOB	Preferred Name:	Medicaid ID #

Consent to participate in Community Integration Services Plus CIS+ (Member must check all boxes):

The following has been explained to me:

☐ Medical respite services. I understand that these services are limited to a maximum of six (6) months in a year.

☐ Housing navigation supports. I understand that these services may be available for limited periods of time.

Based on the information that has been presented to me, I want to [check one]:

☐ ACCEPT: I voluntarily agree to enroll in **Community Integration Services Plus**

☐ REFUSE: I do not want **Community Integration Services Plus**

REASON FOR REFUSAL: _____

By signing below, I understand and agree to the following:

☐ I will take part in CIS+ visits and assessments.

☐ My health plan will approve CIS+ benefits for limited periods of time, based on my needs.

☐ I can choose which CIS+ services I want to receive.

☐ I have the right to pick the CIS+ provider that will deliver and monitor my services.

_____ _____

Member or Advocate/Representative Signature **Date**

If signed by Member Advocate/ Representative,

Relationship to Member: _____ Phone Number: _____

For CIS+ Services Agency, Health Plan, or Delegate Use Only

☐ I attest that I have explained all of the available CIS+ services that the member may be eligible for and the benefit limits. The member had the opportunity to ask questions and provided consent freely.

_____ _____

CIS+ Services Agency, Health Plan, or Delegate Name **Staff Name and Title**