Department of Human Services
Med-QUEST Division

Community Integration Services Plus (CIS+)
Member Consent Form

(Appendix C)

Part 1: Member Information

First Name:	Last Name:	Preferred Name:	Date of Birth:	Medicaid ID #:

Part 2: Health Needs-Based Criteria	Part 3: Housing Criteria
☐ Mental Health, Substance Use, or Complex Physical Health	☐ Sheltered or ☐ Unsheltered Homelessness
	☐ Risk of Imminent Eviction
	☐ Frequent Institutional Stays

Part 4: Member Consent to Participate in Community Integration Services Plus (CIS+)

The following has been explained to me (member must check all boxes):

☐ **Housing Navigation:** I understand that these services may only be available for a certain period and that I must continue to meet eligibility requirements to receive Housing Navigation.

☐ **Medical Respite:** I understand that these services are limited to a maximum of 6 months in a year, and that I must continue to meet eligibility requirements to receive Medical Respite.

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

☐ **ACCEPT:** I voluntarily agree to enroll in Community Integration Services Plus (CIS+).
☐ **REFUSE:** I do not want to enroll in Community Integration Services Plus (CIS+).

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**