



## RIGHTS AND RESPONSIBILITIES

The following programs are part of SHS: Children and Youth with Special Health Care Needs (CYSHCN), Healthy Children and Youth (HCY), Medically Fragile Adult Waiver (MFAW), and Adult Brain Injury (ABI). As a participant or family participating in any of these programs you have the following rights and responsibilities:

### RIGHTS:

- You are entitled to the assignment of a Service Coordinator. This person helps to develop a plan based on service needs and goals that you and your family identify. Each service must be fully understood, how and why it is being provided, and who is responsible for payment. Any changes in the plan will be discussed with you.
- You have the right to request that services be discontinued at any time.
- You have the right at any time to review your record. Information and records of service are confidential and will not be released without your authorization, except as permitted or required by law. (SHS is required to share information with Department of Social Services, as needed, to assure appropriate medical service for MO HealthNet recipients.)
- You have the right to appeal decisions about the services you are receiving. To initiate this process for:
  - CYSHCN and ABI Programs, you must submit a written statement of your concerns to your Service Coordinator. You may expect a written response after your concerns have been reviewed and examined.
  - HCY and MFAW Programs, you must contact MHD Participant Services Unit, PO Box 6500, Jefferson City, MO 65101-6500, in writing or by phone at 1-800-392-2161.

### RESPONSIBILITIES:

- Actively participate in completion of an Assessment and the development of a Service Plan, which includes choosing a provider.
- Actively participate in the development and implementation of a treatment plan for provider services.
- Keep SHS and provider appointments, or request in advance that they be changed.
- Express your opinions and concerns to your Service Coordinator and ask questions when you do not understand.
- Apply for benefits from all agencies/resources that may be able to provide assistance.
- Complete an initial application and provide information as requested to determine and maintain program eligibility.
- Notify SHS immediately of any changes in information such as: your address, telephone number, family size, income, guardian status and/or medical condition.
- Inform the Service Coordinator of any benefits or services you receive from any other agency such as MO HealthNet, Medicare, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Insurance, Vocational Rehabilitation, Department of Mental Health, Department of Health and Senior Services, and any other program.
- Respond promptly to requests made by your Service Coordinator or SHS staff.
- For participants in the CYSHCN Program, you shall make sure the service provider will accept CYSHCN payment and present the CYSHCN Eligibility Card to the service provider before covered services are delivered. If you have private insurance or MO HealthNet, you shall utilize in-network providers.
- For participants in the CYSHCN Program, you shall notify the Service Coordinator prior to receiving medical services that require prior authorization through the CYSHCN Program.
- For participants in the CYSHCN Program, you shall reimburse CYSHCN for the amount expended when you receive money from third party or insurance related to the injury, disability, or disease for which you are covered under the CYSHCN Program.
- For participants in the ABI Program, you shall maintain a lifestyle that does not interfere with active participation in any services provided through the program.

Failure to comply with any of these responsibilities may result in discontinuation from service. If you have questions or concerns, contact your Service Coordinator or call the toll free number (800) 451-0669.

[www.health.mo.gov](http://www.health.mo.gov)

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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SPECIAL HEALTH SERVICES (SHS)  
PO BOX 570, JEFFERSON CITY, MO 65102-0570  
PHONE: 573-751-6246, FAX: 573-751-6237

### RIGHTS AND RESPONSIBILITIES ACKNOWLEDGEMENT FORM

PARTICIPANT NAME	DCN
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Program:  CYSHCN     HCY     MFAW     ABI

**AS A PARTICIPANT, I ACKNOWLEDGE BY SIGNING THIS FORM THAT:**

- 1) I HAVE BEEN INCLUDED IN THE DISCUSSION OF MY RIGHTS AND RESPONSIBILITIES.
- 2) I HAVE RECEIVED A COPY OF MY RIGHTS AND RESPONSIBILITIES.
- 3) I CHOOSE TO CONTINUE MY PROGRAM ENROLLMENT.

PARTICIPANT/GUARDIAN SIGNATURE	SERVICE COORDINATOR/WITNESS SIGNATURE
DATE	DATE

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