NOVA SCOTIA
Department of Health and Wellness

Self Managed Care Decision Form

Continuing Care 1-800-225-7225 toll free across Nova Scotia 8:30 a.m. to 4:30 p.m., 7 days a week

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To Be Completed By Self Managed Care Continuing Care Coordinator

Client Name:	Health Card Number:
District SIN:	Mailing Address
SMC Continuing Care Coordinator Name:	Contact Number (s):

Recommend for Self Managed Care Funding: ◯ YES ◯ NO

If No, Explain:

Attached:

- ☐ Self Managed Care Proposed Client Care Plan
- ☐ Self Managed Care Agreement
- ☐ Self Managed Care Exceptional Request Form (if applicable)

SMC - Continuing Care Coordinator Signature: _____

Date (mm/dd/yyyy) _____

To Be Completed By SMC Supervisor

Self Managed Care (SMC) Funding Decision:

- ☐ Approved Monthly SMC Funding
- ☐ Approved With Exception
- ☐ Deferred

Funds/Month $ _____

Until (Date) _____

☐ Denied

Comments:

Supervisor Signature _____

Date (mm/dd/yyyy) _____