

**Mental Health/Substance Abuse Targeted Case Management
Letter of Attestation
Of Recipient Eligibility**

Mental Health/Substance Abuse Targeted Case Management is a service that assists recipients to gain access to necessary care: medical, behavioral, social, and other services appropriate to their needs. Case management is individualized, person centered, empowering, comprehensive, strengths-based, and outcome-focused. The functions of case management include:

- Case Management Assessment;
- Person Centered Planning;
- Referral/linkage; and
- Monitoring/follow-up.

As a current Medicaid TCM provider I attest to the following:

- I fully understand all the requirements of **Mental Health/Substance Abuse Targeted Case Management**, including, but not limited to, all elements of the definition, eligibility criteria, staff training requirements and staff qualifications.
- Further I understand I am solely responsible for ensuring the service is provided as defined and am attesting to my compliance to the service definition for **Mental Health/Substance Abuse Targeted Case Management effective July 1, 2010**.
- I further attest that the Medicaid recipient listed below has been receiving the case management component of Community Support Services from this agency, and meets the eligibility and continued service criteria as defined in the **Mental Health/Substance Abuse Targeted Case Management** service definition.
- I further attest that once the Medicaid recipient listed below no longer meets criteria to receive **Mental Health/Substance Abuse Targeted Case Management**, as indicated by the following: The recipient has met the goals in the goals outlined in the Person Centered Plan that require case management functions, **OR** the recipient no longer meets Continued Service Criteria, **OR** the recipient or legally responsible person no longer wishes to receive Case Management Services, they will be discharged from **Mental Health/Substance Abuse Targeted Case Management** to either step down or step up in services as needed.

Recipient Name: _____

Date of Birth: _____

Medicaid ID Number: _____

CABHA Provider QP Signature: _____

(Print name) _____

Date: _____

CABHA Agency Name: _____

MH/SA TCM Medicaid Provider Number: _____

Requested MH/SA TCM Authorization Start Date: _____

Community Support Agency Name: _____

Community Support Medicaid Provider Number: _____

Community Support Authorization End Date: _____