MAP-586 (09-91) **Appendix XI**

ASSURANCE OF CASE MANAGEMENT SERVICES CERTIFICATION FORM

I. CLIENT INFORMATION

Client's Name__________________________________Birthdate___________

Medical Assistance Identification Number______________________________

Address of Client____

Responsible Party/Legal Representative_______________________________

Address____

II. CERTIFICATION

Targeted Case Management Services – This is to certify that I/responsible party/legal representative have been informed of my rights with regard to Case Management Services.

I elect ____ or do not elect ___ case management services.

I choose ____________________________ as my Case Management Provider.

I choose ____________________________ as my Case Manager.

_____________________________________ ____________________
Signature Date

Signature and Title of Person Assisting
With Completion of Form____

Agency____

Address____