Directions: Please fill in all blanks, print and sign the form, submit to Family Medicaid by fax at **208-528-5980**. Maintain original in participant's records. You may choose to submit the form electronically to: familymedicaid@idhw.state.id.us

IDENTIFYING INFORMATION

Name of Participant:______________________________ Medicaid ID#:_______________________

Name of Provider Certifying Medicaid Enhanced Plan:

____

Name of Agency and Agency provider#:____

RATIONALE FOR ENHANCED PLAN SERVICES

(Provider: please check the appropriate box as indication of the justification for this participant needing Medicaid Enhanced Plan)

Participant needs the following services:

- ☐ Additional Psychotherapy
- ☐ Partial Care
- ☐ Psychosocial Rehabilitation
- ☐ Service Coordination
- ☐ Developmental Disabilities
- ☐ Inpatient Psychiatric Hospitalization

CERTIFICATION

I have assessed ___________________________ (Name of participant) on _______________ (date) and certify that this participant meets the requirements in IDAPA 16.03.10 for receiving the above indicated services in the Medicaid Enhanced Plan.

____

Signature of Provider Certifying Participant's Eligibility Date