OTP Health Home Opt-out Form

Attestation Statement

For use by OTP Health Home eligible Medicaid client

□ I have met with the case manager for _____
Name of OTP Health Home

who has explained the program to me and the case management services I can receive. I have decided not to join/discontinue my enrollment at this time.

For use by case manager
□ I have discussed _____
Name of OTP Health Home

program with _____. The benefits of membership
Name of Medicaid Member

were explained; however the Medicaid client has decided not to join/un-enroll at this time.

Reason for Opting Out

_____

_____

_____

Signatures

I understand that I will not get a case manager or Health Home services, but I will still continue to get my substance abuse treatment services.

I also understand that should I decide at a later date that I would like to receive Health Home services, I will not be eligible to receive services for 12 months beginning on the date documented below.

_____	_____	_____
Name of Member or Client's Legal Representative (print)	Original Signature	Date

_____	_____	_____
Name of OTP Health Home Case Manger (print)	Original Signature	Date