

Attestation Statement

For use by Health Home eligible Medicaid client

I have met with the care manager for _____
Name of Health Home

who has explained the program to me and the care management services I can get. I have decided not to join at this time.

For use by care manager

I have discussed _____
Name of Health Home

program with _____ over the telephone. The benefits of
Name of Medicaid Member
membership were explained; however, the Medicaid client has decided not to join at this time.

Reason for Opting Out

Signatures

I understand that I will not get a care manager or Health Home services, but I will still continue to get my Medicaid health care services.

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

Name of Health Home Care Manager (print) Original Signature Date

NOTE

If you would ever like to get Health Home services contact the NYS Medicaid Program by calling the Medicaid Call Center at 1-800-541-2831.