HUMAN SERVICES
DEPARTMENT
Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

DEPARTMENTAL MEMORANDUM
MAD-MR: 16-03
DATE: 1/27/2016

TO: **MEDICAL ASSISTANCE DIVISION**

FROM: **NANCY SMITH-LESLIE, DIRECTOR, MEDICAL ASSISTANCE DIVISION**

THROUGH: **MEGAN PFEFFER, QUALITY BUREAU**

BY: **NANCY SMITH, NURSE MANAGER, QUALITY BUREAU**

SUBJECT: **HEALTH HOME OPT-IN/OPT-OUT FORM**

GENERAL INFORMATION
This form will be used for providers to document Medicaid Recipients' preference to opt-in or opt-out of the Health Home program.

FILING INSTRUCTIONS
Please make the following changes to the MAD forms manuals:

INSERT Form #602

Please address any questions concerning these guidelines to Nancy Smith at Nancy.Smith2@state.nm.us or call (505) 827-3161.

Attachment: MAD 602 Issued 1/26/16 Health Home Opt-In/Opt-Out Form

CARELINK NM
YOUR CARE. OUR COMMUNITY

Health Home Opt-In/Opt-Out Form

Opt-In Attestation Statement

For use by Health Home eligible Medicaid Recipient:

I have met with a staff member of CareLink NM who has explained the Health Home program to me and the care coordination services I will receive. I have decided to become a member at this time.

For use by CareLink NM:

I have discussed the CareLink NM Health Home program with_____.
Name of Health Home eligible Recipient

The benefits of membership were explained. The Medicaid Recipient has decided to join.

_____

Name of CareLink NM Staff (Print) **Signature** **Date**

_____

Name of Recipient or Authorized Representative (Print) **Signature** **Date**

Opt-out Attestation Statement

For use by Health Home eligible Medicaid Recipient

I have met with a staff member of CareLink NM who has explained the Health Home program to me and the care coordination services I could receive. I have decided not to become a member at this time.

For use by CareLink NM

I have discussed the CareLink NM Health Home program with _____.
Name of Health Home eligible Recipient

The benefits of membership were explained; however, the Medicaid Recipient has decided not to join at this time.

Reason for Opting Out: _____

_____

Name of CareLink NM Staff (Print) **Signature** **Date**

_____

Name of Member or Authorized Representative (Print) **Signature** **Date**