

COMMUNITY CARE SERVICES

Date: _____

Case No. _____ **(If Available)**
Client No. _____ **(CCS#)**

Dear _____:

If you are a recipient of SSI (Social Security Income) or SSDI (Social Security Disability Income) and you are on **Medicaid**, you may choose to continue to receive your mental health services through CCS. If you make this choice, your medical care will be covered under Medicaid, while your mental health services will be covered under CCS.

Medicaid Fee-for Service for Mental Health

Inpatient stays - limited days may apply
Case Management through the State
Community Mental Health Centers (CMHC)
Outpatient Psychotherapy
Appointments for medication

CCS Coverage for Mental Health

Inpatient stays - no limit on days
Case Management through the same agency you are
now receiving the service, including the CMHCs
Outpatient Psychotherapy
Appointments for medication
Residential treatment
Intensive Outpatient treatment
Psycho-social Rehabilitation services

Staying in CCS gives you more benefits. THE CHOICE IS YOURS. If you do not make a choice you will receive your mental health services through Medicaid Fee-for Service.

Please put an "X" next to your choice (choose only one).

 X I choose CCS for my mental health coverage. A copy of Medicaid Card or Award letter attached.

 I choose Medicaid Fee-for Service for my mental health coverage.

Sign your name: X

Date: X

If you have any questions, please call your case manager or care coordinator.

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