PROVIDER AGENCY ACKNOWLEDGEMENT FOR THERAPEUTIC GROUP CARE SERVICES

Provider Agency Name: ______________________________ Medicaid No.: __________

Provider Agency Address: ____

City: __________________________ Zip Code: _________ Phone No.: ( ) __________

County: ______________________________ Circuit: _________ Area: __________

Name and Address of Site: ____

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______________________________ Zip Code: __________

I certify that the above named site has met the criteria for therapeutic group care services certification and is in compliance with Medicaid policies and procedures as put forth in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook and with the specific standards for therapeutic group care services. I further certify that statements made in this document are accurate and correct to the best of my knowledge.

Executive Director's Signature: ______________________________ Date: __________

Executive Director's Name (please print): ______________________________________

Send original form to AHCA, Medicaid Services, Long Term Care and Behavioral Health Unit, 2727 Mahan Drive, MS 20, Tallahassee, FL 32308.

Provider should maintain a copy.