DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

SDMI LIFE COACH
PROVIDER AND SERVICE REQUIREMENTS ATTESTATION

Name: Date:

Phone Number: Mailing Address:

E-mail Address: Are you enrolling as an:

City/County in which you would like to provide Life Coach services:

The goal of the SDMI HCBS waiver program is to keep members independent in the community for as long as possible and to promote the health and independence of Medicaid members who have a severe disabling mental illness and require long term care. The waiver is centered on recovery for members living within their community utilizing the supports offered by waiver. Members on the waiver strive to reach their fullest potential with help of service supports offered by the waiver, with an emphasis on social participation, attention to the rights of people with mental illness, and equality. The goal is to integrate members into the community in which they live, wherein they become a valued member of their community. The waiver assists with access to opportunities that exist that allow individuals to contribute at the level which they are capable.

I understand as an applicant to provide for the Life Coach service with the SDMI Medicaid Waiver program, I must meet the provider and service requirements as outlined in the HCBS SDMI Policy 340 located here: SDMI HCBS 340 Life Coach. Please note: per policy, each Life Coach must be individually approved by the department, whether employed by an agency or as an independent provider.

Please check each box below to provide for your attestation that you can or will be able to meet the following provider and service requirements:

- ☐ I am at least 18 years of age.
- ☐ I am able to complete 8 hours of Mental Health Training annually.
- ☐ I understand I must submit a quarterly report to the Case Management Team (CMT) which includes the progress on the member's identified SMART goals and the methodologies/activities used by the Life Coach to assist the member in achieving the goals.

☐ I agree to sign an affidavit regarding confidentiality and HIPPA.

☐ I attest I am able to communicate effectively with the Member/Personal Representative.

☐ I agree to a state criminal background check.

☐ I will demonstrate to the member specific competencies necessary to complete paid tasks.

☐ I will complete a self-declaration regarding infections and contagious disease.

☐ I will demonstrate knowledge of how to report abuse, neglect, or exploitation.

☐ I attest that I have read and understand the SDMI HCBS 340 Life Coach policy.

Applicant Signature: Click or tap here to enter text.

Training requirement:

Free Online Mental Health Courses Alison

- Mental Health Support Worker Essentials
- Understanding Mental Health and Psychiatric Disorders
- Mental Health & Psychosocial Support

To obtain a certificate from Alison, you must achieve a score of **80% or more** in each assessment. We do not expect you to pay for the certificate, a screenshot of the certificate is acceptable.

Please submit all required documentation and training certificate within 30 days to:

SDMI Waiver
Department of Health and Human Services/Behavioral Health and Developmental Disabilities
2121 Rosebud Dr. Ste. H
Billings, MT 59106

Or

Fax: (406) 652.1895 Attn: SDMI Waiver
Email: Lori.Laubach-Duncan@mt.gov
Subject: Life Coach Enrollment

Your enrollment request will be processed once the attestation and supplemental information is received. If you have any questions regarding the required documentation for enrollment, please contact Lori Laubach-Duncan, Compliance Specialist, by calling (406) 655-7631 or sending an email to Lori.Laubach-Duncan@mt.gov.