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	**CCS Coverage for Mental Health**
Inpatient stays - limited days may apply	Inpatient stays - no limit on days
Case Management through the State Community Mental Health Centers (CMHC)	Case Management through the same agency you are now receiving the service, including the CMHCs
Outpatient Psychotherapy	Outpatient Psychotherapy
Appointments for medication	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.

810-A N. Vineyard Boulevard * Honolulu, Hawaii 96817 * Telephone 845-7771 * Facsimile 845-7955 * Toll Free (800) 947-8881