Provider AGENCY NAME:	Enter Provider agency full name	
Attestor's Name:	Enter Attestor's name	
1.) I attest that we have Policies and *If No, provide your current policies and procedures and a statement about how you will come into compliance before the next quarterly report.*		Select
2.) I attest our Provider Ratios are in compliance with AMPM 570 and AMPM 570 Attachment A. *No when the caseload Total is over specified ratio (cell should turn red if over ratio and requires completion of the Caseload Over Ratio Explanation for each staff member).*		Select
3.) I attest our Supervisor to Provider Ratios are in compliance with our Policies and Procedures. *If No, complete Supervisor worksheet.*		Select

				Totals	*0*	*0*
						Average Caseloads
Field Name	**Case Manager's Name** (Last Name, First Name)	**Supervisor Name** (Last Name, First Name)	**Agency Site**	**Hire Date** (XX/XX/XXXX)	**Vacated** (1=Yes)	**Percent Dedicated Provider** **(1.00=Full Time)**
Cell Format	Text	Text	Text	Short Date	Whole Number	Decimal
Blanks Allowed	No	No	Yes, when only one location for agency	No	Yes	No
Brief Description		Legal name of the staff's supervisor (no nick names).	Agency site (address or AHCCCS Provider ID specific to the location)	Date the staff member was hired at your agency.	1 (Yes) indicates the staff member is no longer functioning as an Adult Case Manager. If vacated leave staff on report for 1 quarter. *Otherwise leave blank.*	Percentage of time the staff member (regular full/part time) is dedicated as an adult case manager; expressed as a 2 decimal number. 0.10 = 1% or 4 hrs./wk. 0.25 = 25% or 10 hrs./wk. 0.50 = 50% or 20 hrs./wk. 0.75 = 75% or 30 hrs./wk. 1.00 = 100% or 40 hrs./wk.
Conditional Formatting/Cell Highlighting	None	None	None	None	None	None

Totals	*0*		*0*	*0*	*0*	*0*	*0*		*0*
Average Caseloads									
	Supportive Case Management								
	Caseload Ratio: 3~~0~~5:1								
Field Name	**American Indian Health Program**	**NAZ AzCH**	**SAZ AzCH**	**Banner University Family Care**	**Health Choice**	**Mercy Care**	**Molina Healthcare**	**United Healthcare**	**Other**
Cell Format	Whole Number								
Blanks Allowed	Yes, if no caseload for the health plan								
Brief Description	Number of adults with SMI or GMH/SU (when clinically indicated) enrolled with each health plan that are on staff members case load as of the last day of the quarter. (Provider = must: i. For a full FTE (1.0), have a caseload ratio of adults not to exceed 30:1. *Contacted by assigned provider case manager every 30 days, or more often as needed. If no caseload leave blank.								
Conditional Formatting/Cell Highlighting	None								

Totals	*0*		*0*	*0*	*0*	*0*	*0*		*0*	***0***
Average Caseloads										
	Connective Case Management									
	Caseload Ratio: ~~70~~81:1									
Field Name	**American Indian Health Program**	**NAZ AzCH**	**SAZ AzCH**	**Banner University Family Care**	**Health Choice**	**Mercy Care**	**Molina Healthcare**	**United Healthcare**	**Other**	**Total Adult Caseload**
Cell Format	Whole Number									Number
Blanks Allowed	Yes, if no caseload for the health plan									N/A
Brief Description	Number of adults with SMI or GMH/SU (when clinically indicated) enrolled with each health plan that are on staff members case load as of the last of the quarter. (Provider = must: i. For a full FTE (1.0), have a caseload ratio of not to exceed 70:1. *Contacted by assigned provider case manager every 90 days, or more often as needed. If no caseload leave blank.									Auto-Calculated Total Do not manipulate.
Conditional Formatting/Cell Highlighting	None									When Caseload >30

Totals	*0*		*0*	*0*	*0*	*0*	*0*		*0*	***0***	***0***	
Average Caseloads												
	ACT Caseload											
	Caseload Ratio: 10:1											
Field Name	**American Indian Health Program**	**NAZ AzCH**	**SAZ AzCH**	**Banner University Family Care**	**Health Choice**	**Mercy Care**	**Molina Healthcare**	**United Healthcare**	**Other**	**Total ACT Caseload**	**Total Combined Caseload**	**Caseload Over Ratio/Blended Caseload Explanation**
Cell Format	Whole Number									Number	Number	Text
Blanks Allowed	Yes, if no caseload for the health plan									N/A	N/A	Yes, if staff ratios do not exceed specified ratio
Brief Description	Number of ACT members that are on staff members caseload as of the last day of the quarter. Provider are not allowed to have any other members on their caseload when providing ACT Team services. Refer to the SAMHSA ACT "Evaluating Your Program" criteria "H.1 Small Caseload" to determine applicable ACT Staff. If no caseload leave blank.									Auto-Calculated Total Do not manipulate.	Auto-Calculated Total Do not manipulate.	Provide a detailed explanation of why the caseload exceeds ratio (i.e. open positions) Update each quarter, do not leave CM info in the section after the quarter it is reported.
Conditional Formatting/Cell Highlighting	None									When Caseload >0	When either **Caseload** >30 OR **Caseload** >0	None

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Provider Agency Name:	Enter Provider agency full name
Attestor's Name:	Enter Attestor's name

1.) I attest that we have Policies and Procedures that align with the Provider ratios and supervisor requirements identified in AMPM Policy 570.
If No, provide your current policies and procedures and a statement about how you will come into compliance before the next quarterly report.
2.) I attest our Provider Ratios are in compliance with AMPM Policy 570 and AMPM Policy 570 Attachment A.
Select No when the caseload Total is greater than specified ratio (cell should turn red if over ratio and requires completion of the Caseload Over Ratio Explanation for each staff member).
3.) I attest our Supervisor to Provider Ratios are in compliance with our Policies and Procedures.
If No, complete Supervisor worksheet.

Totals | Average Caseloads

Case Manager's Name (Last Name, First Name)	Supervisor Name (Last Name, First Name)	Agency Site	Hire Date (XX/XX/XXXX)	Vacated (1=Yes)	% Dedicated CM (1.00=Full Time)	DDD-GMHSU Supportive Caseloads	DDD-GMHSU Connective Caseloads	DDD-SMI *Assertive (ACT) Caseloads	DDD-SMI *Supportive Caseloads	DDD-SMI *Connective Caseloads	GMHSU Supportive Caseloads	GMHSU Connective Caseloads	SMI *Assertive (ACT) Caseloads	SMI *Supportive Caseloads	SMI *Connective Caseloads	Any AHCCCS Approved Caseloads	Caseloads Total	Caseload Over Ratio Explanation

Provider AGENCY NAME:	Provider agency full name

*ONLY COMPLETE IF CANNOT ANSWER "YES" TO ATTESTATION 3 ON ADULT WORKSHEET

Field Name	Current Supervisor Employed	Agency Site	Hire Date (XX/XX/XXXX)	Vacated (1=Yes)	Full or Part Time Dedicated to supervision - stated as decimal Percent of Full Time Employee (FTE) (1.00=Full Time)	Total number of Case Managers supervised	Supervisor Over Ratio Explanations
Cell Format	Text	Text	Short Date	Whole Number	Decimal	Whole Number	Text
Blanks Allowed	No	No	No	Yes if not vacated	No	No	Yes if no caseload overage
Brief Description	Supervisors legal name (no nick names), only if you do not have Policies and procedures that align with the supervision practices in AMPM 570 or you are out of compliance with your Policies and Procedures.	Case management agency site.	Date the staff member was hired at your agency.	1 (Yes) indicates the staff member is no longer functioning as a Adult Case Manager Supervisor. If vacated leave staff on report for 1 quarter, for example if the supervisor leaves in January and is reported in March, in the June report their name would be removed. Otherwise leave blank.	Percentage of time the staff member (regular full/part time) is dedicated to supervision of Adult Case Managers; expressed as a 2 decimal number. 0.10 = 1% or 4 hrs./wk. 0.25 = 25% or 10 hrs./wk. 0.50 = 50% or 20 hrs./wk. 0.75 = 75% or 30 hrs./wk. 1.00 = 100% or 40 hrs./wk.	Total number of case managers the staff member supervises.	Detailed explanation of why each supervisor to staff ratio does not align with your policies and procedures. Include information about open positions, newly hired staff or staff leaving, any actions taken to address the non-compliance.

Provider Agency Name:	Enter Provider agency full name here

*ONLY COMPLETE IF CANNOT ANSWER "YES" TO ATTESTATION on ADULT worksheets

Supervisor's Name (Last Name, First Name)	**Agency Site**	**Hire Date** (XX/XX/XXXX)	**Vacated** (1=Yes)	**Percent Employed** (1.00=Full Time)	**Total number of Case Managers supervised**	**Supervisor Over Ratio Explanations**
Totals			0	0.00	0	
				Average Caseload	***#DIV/0!***	