



State of Maine Department of Health Human Services
Community Case Management Program Permission for
Services Form

Name of Consumer:

MaineCare #:

Date of Birth:

I/We have been informed that we have the option of choosing case management services from any certified Community Case Management (CCM) agency*. I understand I may not receive CCM services from an agency that already provides me with other services.

With this information, I/We have selected _____ for Adult Community Case Management services.

I/We further understand that I/We may decide to change our case management services to another agency contracted to provide this service at any time.

I/We give permission for _____ to access personal records on the Enterprise Information System (EIS).

Consumer Signature

Date

Parent/Guardian Signature

Date

Printed name of person authorizing release

Date

CCM

Date

** Certified Community Case Management agencies are those agencies approved by the Office of Aging and Disability Services (OADS) to be in compliance with rule standards under 14-197 Chapter 10 and provide services under the provisions of the MaineCare Manual (10-144 CMR 101), Chapter II, Section 13, Targeted Case Management.*