CSA Reimbursement Rate Certification
Residential Treatment and Treatment Foster Care

Name of Child: ____

Medicaid Number: ____

Residential Treatment or Foster Care – Case Management Provider:

Bridges Treatment Center, 693 Leesville Road, Lynchburg, VA 24502

Provider Number: 1629172838

Community Policy and Management Team

County/City: ____

Address: ____
Street

____
City State Zip Code

I certify that the following rate, $_______________ per day, as been negotiated for the above child for Medicaid reimbursable (check one) . . .

_____ Residential Treatment

_____ Treatment Foster Care – Case Management

The Medicaid rate noted should reflect the negotiated rate minus expected reimbursement from all other payment sources, such as Title IV-E. The total reimbursement from all other sources cannot exceed the Medicaid maximum rate for this service.

This rate shall be effective for date of service beginning ___________________________.
MONTH/DAY/YEAR

CPMT Signature: ____

Print Name: ____

Title: ____

Date: ____

Date must be of the current year

updated 10/18/17