TN Department of Disability & Aging | Family Support Program

ECF ATTESTATION FORM

Date: _____ Family Support Provider Agency: _____

Name of Person Supported: _____

Address of Person Supported: _____

_____

_____

Phone Number of Person Supported: _____

I, _____ (*name of Person Supported*), hereby attest that I began (or will begin) receiving Employment and Community First CHOICES (ECF) services on the ____ day of _____, 20__. **I understand and acknowledge that Family Support funds will only be reimbursed for approved services that were provided no later than the last day before I received ECF services unless the approved service was for a one-time expense.** If a one-time expense was approved, I attest that the service began before I received any ECF service and that it will be completed as quickly as possible pursuant to the terms of my approved claim and service plan. Furthermore, the receipt(s) for any approved service will be submitted to my Family Support provider agency within thirty (30) days of the completion of the service.

I understand that any Family Support funds spent without prior approval after ECF services begin will not be reimbursed by Family Support. Furthermore, if funds are paid by Family Support for unapproved services after ECF services began, then I acknowledge that those funds will be subject to recoupment which means that I will be responsible for reimbursing those funds and may be subject to any additional costs associated with the recoupment of those funds.

I hereby attest that the information provided in this form is true and accurate to the best of my knowledge.

_____

Signature of Person Supported or Legal Representative

Note: Return this signed form to your Family Support provider agency and include a copy of the letter received from the MCO that indicates when ECF services begin.