AGENCY BASED COMMUNITY BENEFITS - ABCB
ABCB PROGRAM ASSURANCES

Organization		Date	
Name		Title	
Email address		Phone Number	

1. INTENT TO COMPLY

Our agency intends to comply with applicable New Mexico laws, regulations, policies and procedures for the Agency Based Community Benefits (ABCB) Program.

Initial here:_____

2. RELATIONSHIPS

Statement A

Relationships to other organizations currently providing Medicaid waiver services **that the provider directly or indirectly controls or influences**

Please enter details of relationships below, and continue on a separate sheet if necessary, or respond "None":

Response_____

_____

Statement B

Relationship to other organizations currently providing Medicaid waiver services **that directly or indirectly control or influence the provider**

Please enter details of relationships below, and continue on a separate sheet if necessary, or respond "None":

Response_____

_____

3. TRANSITION PLAN

This agency will develop a detailed Transition Plan for clients served in the event an Agency Based Community Benefits recipient is discharged or either party terminates the provider agreement.

Initial here:_____

ABCB PROGRAM ASSURANCES

4. CRITICAL INCIDENT REPORTING

Critical Incidents include Abuse, Neglect, Exploitation, Death, Environmental Hazards, Missing/Elopement, Law Enforcement, and Emergency Services.

All ABCB providers must comply with the Health Care Authority's Critical Incident Reporting requirements. **Please see our Managed Care Policy Manual, Section 18.3 (pages 376-377), and see:** https://www.hsd.state.nm.us/providers/critical-incident-reporting/

Please complete:

Our agency intends to comply with the New Mexico Health Care Authority's Critical Incident Reporting requirements.

Initial here:_____

5. POLICY MANUAL SERVICE DESCRIPTIONS AND PROVIDER REQUIREMENTS

The Managed Care Policy Manual can be found at:
https://www.hsd.state.nm.us/providers/managed-care-policy-manual/

I have read the section(s) in Chapter 8 of the Managed Care Policy Manual containing the service description and provider requirements of the ABCB services requested on our agency's completed Scope of Work Service Summary Form, and *(please check which applies below)*:

- ☐ **I do have questions at this time** *(you will be contacted)*
- ☐ **I do not have any questions at this time**

Initial here:_____

Signed:	**Name:**	**Date:**