



Western Highlands Network
A LOCAL MANAGEMENT ENTITY

Dear County Director of Social Services:

_____, a Medicaid eligible child/adolescent in your custody
(Name of Child/Adolescent)

has been determined to meet medical necessity criteria for residential placement in a residential treatment program. _____ will be providing these services.
(Name of Provider)

Although Medicaid will be paying the treatment costs of this service for as long as the service is medically necessary, Medicaid does not cover the cost of room and board. Those expenses are the responsibility of the County Department of Social Services, since the child/adolescent is in your custody. This is to inform you that room and board payments in accordance with the statewide foster care rates of \$_____ per day will be due to the provider to cover this
(Daily rate, based on age of child/adolescent)

cost for all days of service rendered by the provider as long as the child remains in your custody and the service continues to be medically necessary.

Please contact Marsha Ring at (828) 225-2800 if you have any questions.

Sincerely,

Marsha Ring

cc: Provider Agency