Tribal Outreach Attestation Submission

(To be submitted through the DSM email address below along with list of patient registration and outreach lists)
Deadline: 45th day after the close of the prior quarter
Send to: dhcs.tmac@hss.soa.directak.net

Tribe or Tribal Health Organization: _____

TMAC Manager: _____ **Tel:** _____

DSM: _____

Email: _____

Address: _____

City: _____ **Zip:** _____

Please Specify Quarter and FFY: FFY21, QTR1 (OCT 1, 2020 - DEC 31, 2020)

Please Specify Outreach Numbers

# of Individuals Outreached at Registration	
# of Individuals Outreached at Other: (please specify below)	
Other:	
Other:	
Other:	
Total # of Individuals Outreached	0

I, _____, (TMAC Manager) certify and attest that all patient registrants presenting in the undersigned quarter, for the Tribal health medical services, were outreached and provided an explanation, either verbally or visually, of the DenaliCare and/or Denali KidCare public insurance programs, for which they may be eligible, including both local Tribal contact and state contact information.

In addition, If this Tribe or Tribal health organization is the recipient of a CMS Connecting Kids to Coverage Grant or any other CMS grant award for Medicaid administrative activities, I certify and attest that the children who have been outreached and provided application and renewal assistance under the Connecting Kids to Coverage grant or any other federal grant funding for Medicaid outreach and enrollment assistance may also appear in this list since the aggregate total of children outreached and provided application and renewal assistance will likely be a part of this list; however, those children will be eliminated from the unduplicated list of recipients that the Tribe and Tribal health organization submit along with the invoice for payment under TMAC, to carve out these children to prevent duplication of payment for these Medicaid administrative activities (please refer to corresponding invoice attestation).

TMAC Manager: _____

TMAC Manager Signature: _____

Date: _____